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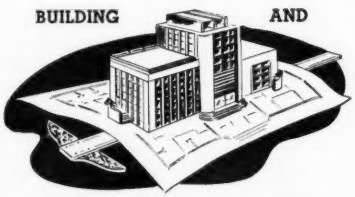

Problems of pre-opening program

Architect-physician building roles

the news and technical journal of administration

March · 1952

Hotpoint griddles automatically better!

Shown above is Hotpoint's superb new Griddle model HGG47, now available with twin fully-automatic temperature controls—preheats to 400° in only 15 minutes.

Every food has an exact temperature at which it griddles best. Now Hotpoint lets you dial-in that exact temperature and hold it—automatically—for automatically better food results!

Two "HOTPOINT FIRST" features are the big reasons for griddling results finer than you have ever seen before. Exclusive Calrod® Heating Units pour *more* heat into Hotpoint Griddles *faster!* And Hotpoint's exclusive Compensated Hydraulic Thermostat controls the heat *better!*

These two developments automatically combine with other Hotpoint Griddle features to give you . . .

. . . AUTOMATICALLY FASTER COOKING! For example, the HG2 Griddle is the world's fastest . . . preheats to 400° in 8 short minutes! The HG3 Griddle-Grill, with top *and* bottom heat, cooks twice as fast! And all Hotpoint Griddles idle automatically at ready-to-cook temperatures.

. . . AUTOMATICALLY LONGER LIFE! Rugged construction plus clean all-electric operation helps Hotpoint Griddles last up to twice as long as ordinary equipment . . . so that in the long run they usually cost less to own than even the least expensive griddles.

. . . AUTOMATICALLY BETTER QUALITY CONTROL! With uniform electric heat distribution, products started together finish together to the same perfect degree of "doneness."

So make an automatic choice for your next griddle now—one of the Hotpoint Automatic Griddles shown below. Count on them to give you *better* food in *greater* volume at *lower* cost . . . automatically!

FOOD SERVICE EXPERTS AGREE

HOTPOINT FIRST

with most important cooking improvements today!

J. H. Holcomb, Jr.
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Britling Cafeterias
Birmingham, Ala.

G. Konnersman, Jr.
President, Industrial Food Service, Inc.
Cincinnati, Ohio

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Frank T. Hilliker & Associates
Design Consultants
St. Louis, Mo.

Dan Clark
Clark's Lunch Rooms, Inc.
South Bend, Ind.

Miss Helen Corbitt
Director of Food Service, Joske's Restaurant
Houston, Texas

The jury of food-service authorities shown above voted Hotpoint **First In Commercial Cooking** for such major exclusive developments as:

Calrod Heating Units • Hotpoint SUPERange (with Recipe Robotrol) • Complete Custom Matched Counter Line • First Commercial Roaster (Dutch Oven-ROASTER) • The Magnificent Glamour Line

AND IT'S ALL BECAUSE...

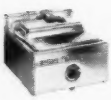
Hotpoint *invented cooking the modern way!*

Check Boxes Below and Mail Coupon for Free Information

☐ **Model HG2**
Unit of the Custom-Matched Counter Kitchen. 212 sq. in. usable fry area.

☐ **Model G28**
For extra counter capacity. 389 sq. in. fry area. Finished in chrome.

☐ **Model HG3**
Griddle Grill—Top and bottom heat cuts cooking time in half.



☐ **Model HGG47**
For big kitchen operation. 615 sq. in. usable fry area.

☐ **Model HGG47 with HXG8 Stand**
Mounts on counter or stand.

HOTPOINT INC.
Commercial Equipment Department
245 South Seeley Ave., Chicago 12, Illinois

We are interested in the Hotpoint Griddle(s) checked. Please send us additional free information and descriptive literature.

Name_____

Title_____ **Firm**_____

Address_____

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HOSPITAL MANAGEMENT is published on the fifteenth of each month at 200 E. Illinois St., Chicago 11, Illinois, by Hospital Management, Inc. Telephone: DElaware 7-1337

HOSPITAL MANAGEMENT is a member of the Audit Bureau of Circulations and Associated Business Papers, Inc.

Subscription rates: single copy, 20 cents; $2.00 a year in the United States, Canada and Pan-American countries. Foreign subscriptions, $2.50 a year.

Entered as second class matter May 14, 1917 at postoffice, Chicago, Ill., under the act of March 3, 1879. Additional entry, Mendota, Ill.

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as others see us

Citizens build own hospital . . . . in Ennis Montana

■ THOUGH the color is still drained from his face, Steve Hubner's breathing is steady and deep now. In his hospital room in Ennis, Montana, a faint sickish sweetness lingers and you recognize it at once as an ether smell. Mrs. Martha Flowers, the nurse, moves over to adjust the crisp, white sheets around the sleeping boy and slips quietly out to find his father.

In the corridor Mr. Hubner is still numb with fear. "Our little boy would have bled to death," he keeps saying, "if the new hospital hadn't been so close. . . . Steven would have bled to death!"

It was just a little more than an hour ago when a friend's 12-gauge shotgun exploded, catching Steve at close range, and ripping his side wide open. A great quantity of precious blood had poured out before they could get him here.

"Steve will be all right," soft-spoken Mrs. Flowers reassures the anxious little group, and you feel the tension lift as she turns back to the room.

Tragedy . . has struck often among the 1,300 sober-minded, hard-working residents of Ennis and surrounding Madison Valley. They tell you about Billy Sprout, who suffered a concussion when his new pony bucked and threw him to the ground, and about a sixty-five-year-old man who was pinned for hours under his horse on a mountain top. And a young woman, whose appendix ruptured suddenly without warning.

In cosmopolitan Butte, 86 miles west by automobile, or Bozeman, 80 miles north, such accidents might pass with little more than usual concern. But here in this isolated corner of Southwestern Montana, where winter arrives early and stays late, they are matters often of heartbreaking consequence.

Until the Madison Valley Hospital opened in Ennis in September, 1950, a premature baby hadn't much chance of surviving a frantic rush through snow-choked mountain passes to a distant town, if medical attention was needed. Those with sudden, serious injuries . . like

continued on page 62

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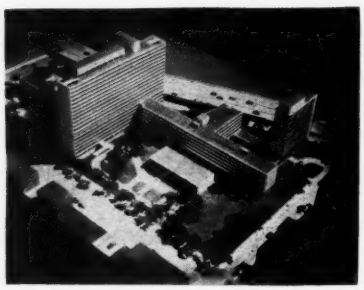
The cover picture



■ THE NEW BELLEVUE MEDICAL CENTER, in New York, shown here in model form, represents some of the latest thinking in hospital design. The architects are Skidmore, Owings and Merrill. This photo was made available by the Aluminum Window Manufacturers Association. ■

new how's business department with the american association of hospital accountants

by F. James Doyle

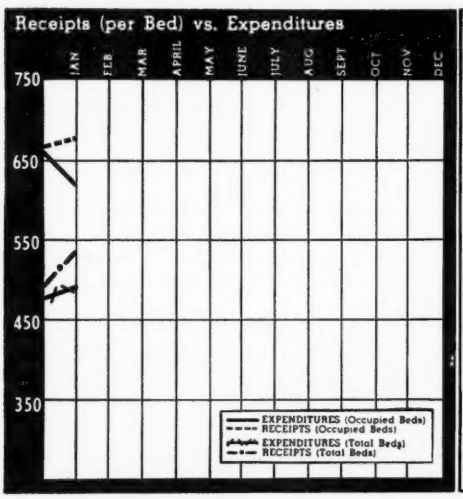
■ THE STATISTICS GIVEN THIS MONTH are those for January and thus begin another year of describing the economic operation of the nation's hospitals.

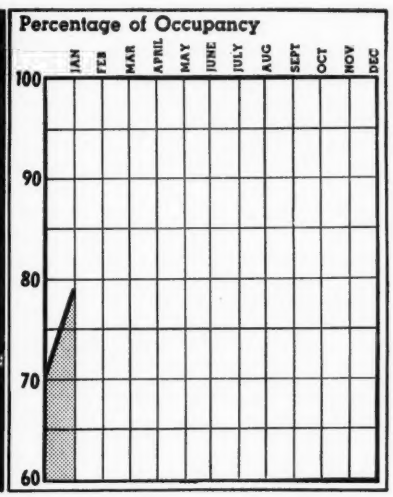
The most noticeable feature is the beginning of the annual January-February rise in occupancy . . a cyclic phenomenon which may be observed in each of the six years graphed at the bottom of this page.

Regionally, Middle Atlantic, South Central and the Pacific Coast seem to be mavericks from the tendency of the rest of the country to keep expenses and charges per occupied beds in fairly close relation. These three areas manifest an astonishing difference between the two figures. Why their charges should exceed their expenditures by so much is difficult to understand. Perhaps accountants from those regions will enlighten us.

Again, any hospitals not now participating in sending data, who wish to do so, can be placed on our mailing list by sending name and address to F. James Doyle, How's Business Editor, Hospital Management, 200 E. Illinois St., Chicago 11, Illinois. ■

National Averages





Average Monthly Occupancy (on 100 per cent basis)

November, 1949	79.90
December, 1949	71.28
January, 1950	78.25
February, 1950	80.44
March, 1950	79.20
April, 1950	77.67
May, 1950	76.54
June, 1950	76.26
July, 1950	73.38
August, 1950	74.90
September, 1950	73.62
October, 1950	77.10
November, 1950	76.63
December, 1950	71.57
January, 1951	80.58
February, 1951	81.82
March, 1951	82.05
April, 1951	78.60
May, 1951	76.98
June, 1951	79.50
July, 1951	75.70
August, 1951	75.72
September, 1951	76.84
October, 1951	77.26
November, 1951	75.70
December, 1951	71.13
January, 1952	78.81

Av. Operating Expenditures Per Occupied Bed Per Month

December, 1950	610.44
January, 1951	568.78
February, 1951	520.72
March, 1951	564.51
April, 1951	580.44
May, 1951	623.84
June, 1951	568.14
July, 1951	566.22
August, 1951	623.94
September, 1951	584.22
October, 1951	593.68
November, 1951	597.14
December, 1951	668.52
January, 1952	623.00

Average Patient Charges Per Occupied Bed Per Month

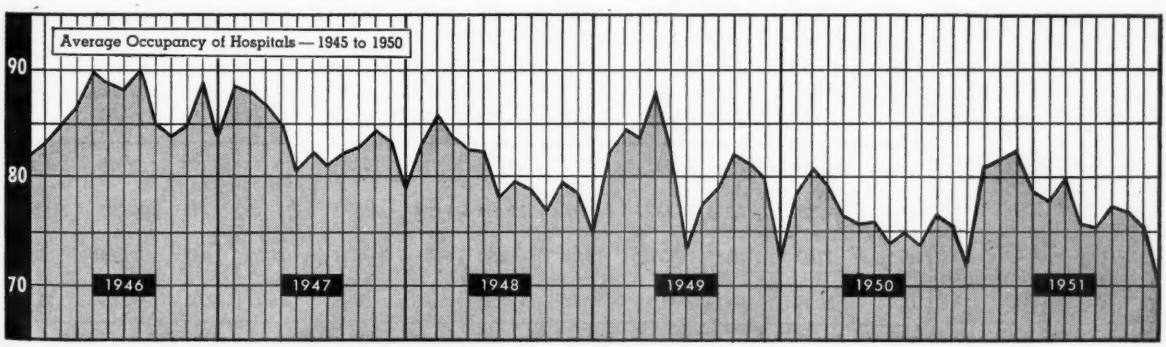
December, 1950	550.19
January, 1951	574.86
February, 1951	543.16
March, 1951	579.46
April, 1951	606.60
May, 1951	664.22
June, 1951	580.15
July, 1951	588.05
August, 1951	641.61
September, 1951	610.90
October, 1951	644.73
November, 1951	625.06
December, 1951	662.84
January, 1952	676.14

Av. Operating Expenditures Per Bed Per Month (Total Beds)

December, 1950	452.03
January, 1951	467.08
February, 1951	432.10
March, 1951	471.00
April, 1951	460.21
May, 1951	488.40
June, 1951	452.67
July, 1951	433.33
August, 1951	474.23
September, 1951	451.99
October, 1951	462.48
November, 1951	464.99
December, 1951	484.14
January, 1952	494.92

Average Patient Charges Per Bed Per Month (Total Beds)

December, 1950	405.18
January, 1951	472.07
February, 1951	450.90
March, 1951	483.47
April, 1951	488.87
May, 1951	520.01
June, 1951	469.41
July, 1951	450.03
August, 1951	487.66
September, 1951	472.62
October, 1951	502.26
November, 1951	486.73
December, 1951	479.44
January, 1952	537.13



January 1952 regional how's business report

REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,079	2,377	11,082	1,516	4,318	9,293	1,878	3,638	8,463	1,444	3,603	10,081
% of OCCUPANCY	58.24%	59.21%	85.08%	72.46%	82.91%	90.32%	73.87%	73.44%	80.17%	66.20%	78.40%	92.43%
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$2.14	$2.40	$2.68	$1.33	$2.32	$2.03	$1.09	$1.70	$2.29	$1.37	$1.96	$2.06
Dietary	3.57	3.17	3.57	2.56	3.27	3.24	2.24	3.20	3.39	2.39	2.69	2.50
Housekeeping	.87	1.32	1.14	.57	.87	1.03	1.01	.92	1.06	.89	1.02	.86
Laundry	.60	.64	.49	.38	.44	.44	.49	.40	.56	.50	.40	.32
Plant Operation	1.91	2.10	1.57	1.56	1.62	1.43	.95	1.13	1.57	1.02	1.00	1.14
Medical & Surgical	.80	1.13	1.11	.41	1.01	.97	.46	1.29	1.86	1.33	.89	1.04
O. R. & Del. Rms.	.61	1.47	1.06	.84	.72	.93	.76	1.25	1.39	1.53	1.34	1.25
Pharmacy	1.07	1.18	.81	1.07	.73	.85	.65	1.03	1.25	1.76	1.13	1.56
Nursing	4.69	6.16	4.83	3.73	4.43	4.47	3.51	4.70	5.70	5.04	5.01	4.26
Anesthesia	.32	.66	.49	.46	.46	.54	.26	.45	.58	.27	.59	.39
Laboratory	.69	1.02	1.06	.76	.98	.82	.43	1.14	1.01	.64	.80	.95
X-ray	.86	1.92	.86	1.43	1.03	.58	.38	.81	.85	.51	.70	.81
Other special services	.09	.15	.90	.44	.49	.56	.25	.33	.72	.20	.82	.31
TOTAL EXPENSES	19,238	54,005	226,856	23,386	79,386	164,968	22,699	65,293	186,825	25,163	64,154	174,597
TOTAL CHARGES TO PATIENTS	18,649	48,105	237,005	25,099	84,153	188,118	24,526	68,064	193,519	27,456	66,695	209,516
OPERATING INCOME PER PATIENT DAY	17.29	20.24	21.39	16.55	19.49	20.24	13.06	18.71	22.87	18.86	18.51	20.78
OPERATING EXPENSES PER PATIENT DAY	17.83	22.72	20.47	15.42	18.39	17.75	12.09	17.95	22.08	17.74	17.81	17.32

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,455	3,683	8,986	1,685	4,485	11,969	1,861	3,711	6,085	1,647	3,832	7,416
% of OCCUPANCY	77.25%	84.06%	85.72%	82.68%	83.05%	86.53%	81.12%	82.57%	84.85%	75.88%	75.14%	79.74%
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.79	$2.50	$2.07	$1.60	$1.66	$1.92	$1.48	$1.21	$2.22	$2.84	$4.67	$3.73
Dietary	2.25	3.49	3.00	2.46	2.96	2.81	2.41	2.83	3.07	2.81	4.36	3.70
Housekeeping	.68	1.03	1.29	.66	.95	.93	.87	1.08	.70	1.50	1.75	1.86
Laundry	.51	.61	.52	.42	.46	.37	.37	.46	.42	.61	.83	.71
Plant Operation	1.43	1.56	1.52	.80	1.38	1.67	1.21	1.34	.97	.97	1.46	1.51
Medical & Surgical	.87	1.68	1.21	.77	1.08	.81	1.19	1.77	.97	1.46	1.25	2.25
O. R. & Del. Rms.	1.20	1.35	1.11	1.05	1.32	1.24	2.21	1.67	.96	1.48	2.17	2.33
Pharmacy	.95	.73	.85	1.41	1.09	.97	2.18	1.54	1.95	.84	1.08	1.85
Nursing	4.89	4.65	5.01	3.98	4.35	4.44	4.95	3.97	4.92	6.97	8.17	7.68
Anesthesia	.25	.40	.46	.36	.37	.41	—	.81	—	.78	.68	.87
Laboratory	.58	1.42	.96	.46	1.02	1.12	1.45	1.13	.85	2.60	1.73	1.66
X-ray	.99	1.20	1.15	.56	.64	.50	.75	1.02	.61	1.61	1.40	1.56
Other special services	.31	.43	.61	.26	.38	.52	.31	.30	.47	.23	1.06	.61
TOTAL EXPENSES	22,921	76,324	177,712	24,437	77,748	209,716	33,023	70,009	110,175	34,709	115,075	214,223
TOTAL CHARGES TO PATIENTS	24,303	84,220	187,557	25,722	84,425	226,614	24,947	71,146	123,425	40,299	126,227	241,557
OPERATING INCOME PER PATIENT DAY	16.70	22.87	20.87	15.26	18.82	18.93	19.47	19.17	20.28	24.47	32.94	32.57
OPERATING EXPENSES PER PATIENT DAY	15.75	20.72	19.78	14.50	17.33	17.52	18.78	18.86	18.11	22.08	30.03	29.89

One Nurse Does the Job of Many!

THE *New* HAUSTED WAY

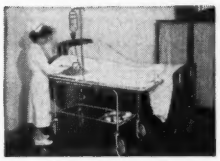
THE HAUSTED "EASY LIFT" WHEEL STRETCHER

The Hausted Wheel Stretcher is the most revolutionary new development in stretchers ever offered. NOW, FOR THE FIRST TIME, HOSPITALS CAN PURCHASE ONE UNIT TO DO ALL THE JOBS OF PATIENT TRANSPORTATION NEEDED. The Hausted "Easy Lift" requires only one nurse to care for even the heaviest patient. And, what's more, with this unit no physical exertion is required of hospital personnel - the stretcher does all the work. By turning one control the patient is transferred from stretcher to bed, quickly, easily, and safely. The unit is available in Silver-Lustre finish. The Hausted stretcher easily adjusts to the height of any Hospital Bed. Stretcher width is 26 inches and length is 72 inches. THE HAUSTED "EASY LIFT" STRETCHER IS IDEAL FOR POST-ANESTHESIA AND RECOVERY ROOM.

THE "EASY-LIFT" NOW HAS TRENDELENBURG POWER-LIFT

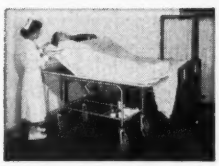
A new and important addition to the labor-saving Hausted "Easy-Lift" stretcher is the Power-Lift mechanism that enables a nurse to raise the stretcher to trendelenburg position by simply turning the new Power-Lift Crank.

Special full length side rails and shoulder stops make stretchers adaptable for recovery and emergency use.



INTRAVENOUS ATTACHMENT

No longer need we see the presently familiar sight of a nurse walking beside a stretcher holding a bottle of fluid in the air. The Hausted attachment eliminates the need for an extra nurse.



THE FOWLER POSITION

By adding the Fowler attachment the Stretcher can be put into proper position in a matter of seconds. This stretcher meets every requirement in transferring patients.

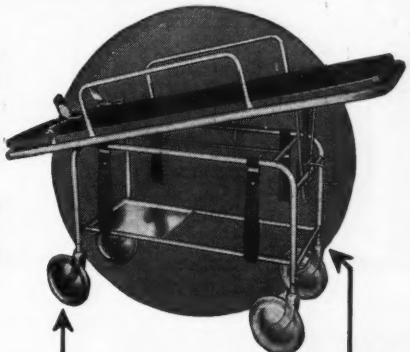
THE TOP FITS OVER THE BED

This is the feature that distinguishes Hausted Wheel Stretchers. The stretcher top fits 3¾ inches over the edge of the bed for easier, quicker, and safer patient transfers. The Hausted Standard Stretcher enables just two nurses to transfer even the heaviest patient without fear of disturbing or harming the patient and without strain to the attendants.

THE HAUSTED LOW COST STANDARD WHEEL STRETCHER

This new, low-cost STANDARD STRETCHER provides hospitals with the answer to easier patient transfers. Its sturdy construction and its versatility are the results of careful engineering and research into hospital needs.

The Standard Stretcher's over-the-bed feature is outstanding among its many advantages. Special side rails are available for post-operative or spinal anesthesia use.



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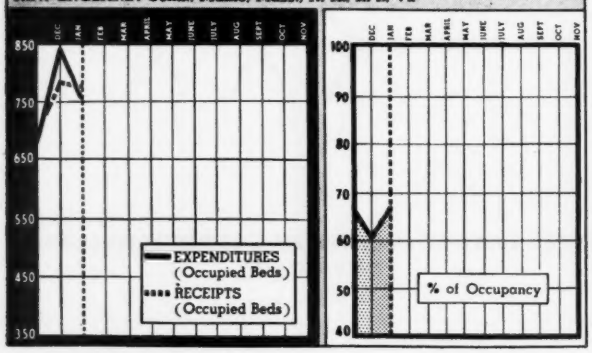
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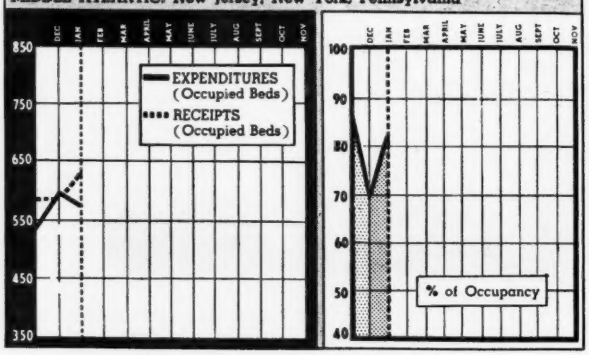
MIDDLE ATLANTIC: New Jersey, New York, Pennsylvania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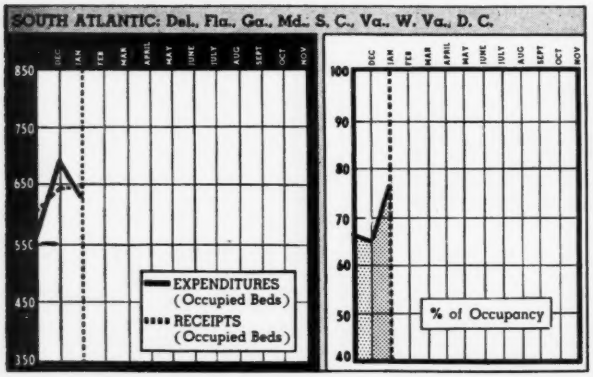
SOUTH ATLANTIC: Del., Fla., Ga., Md., S. C., Va., W. Va., D. C.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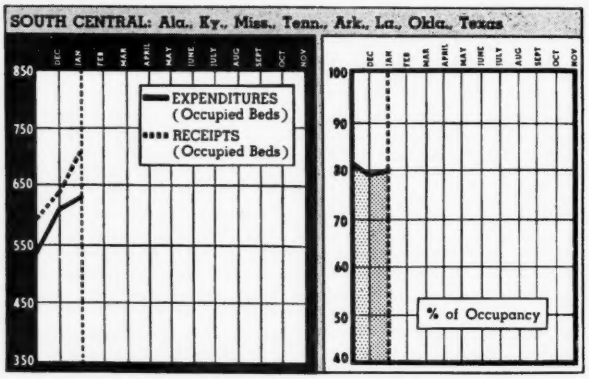
SOUTH CENTRAL: Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas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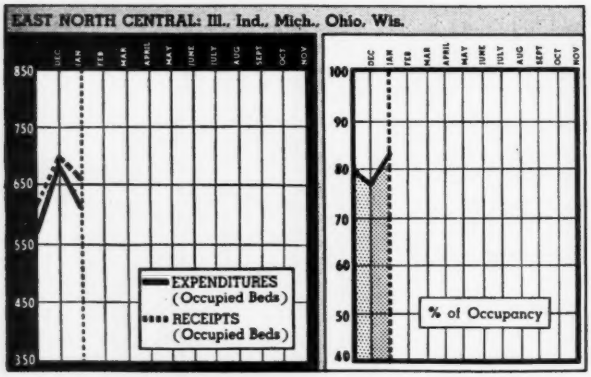
EAST NORTH CENTRAL: Ill., Ind., Mich., Ohio, Wis.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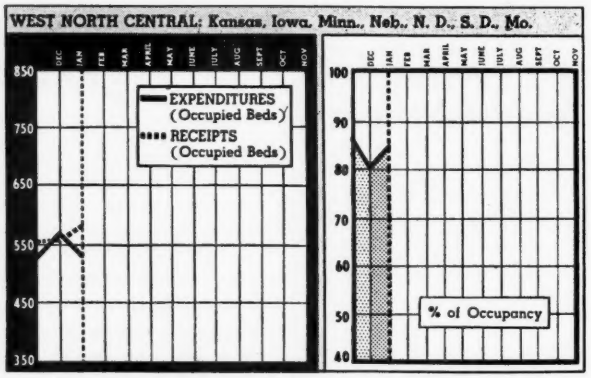
WEST NORTH CENTRAL: Kansas, Iowa, Minn., Neb., N. D., S. D., Mo.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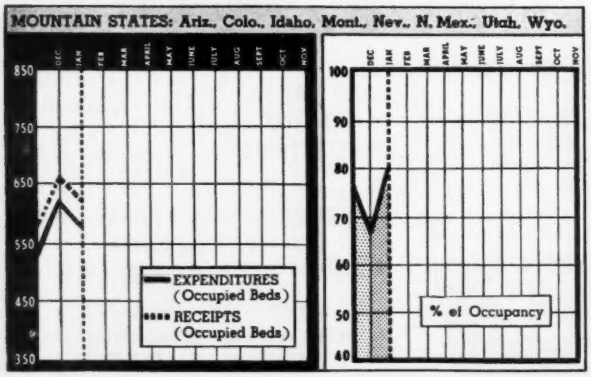
MOUNTAIN STATES: Ariz., Colo., Idaho, Mont., Nev., N. Mex., Utah, Wyo.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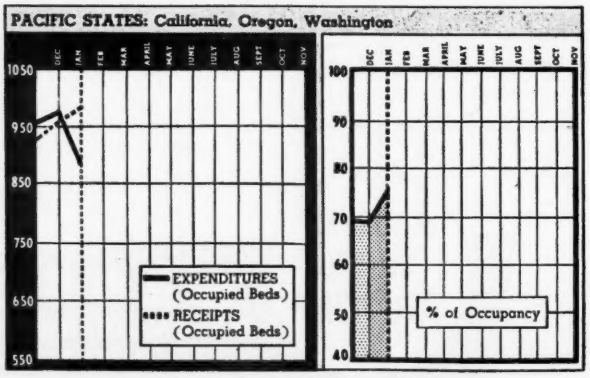
PACIFIC STATES: California, Oregon, Washington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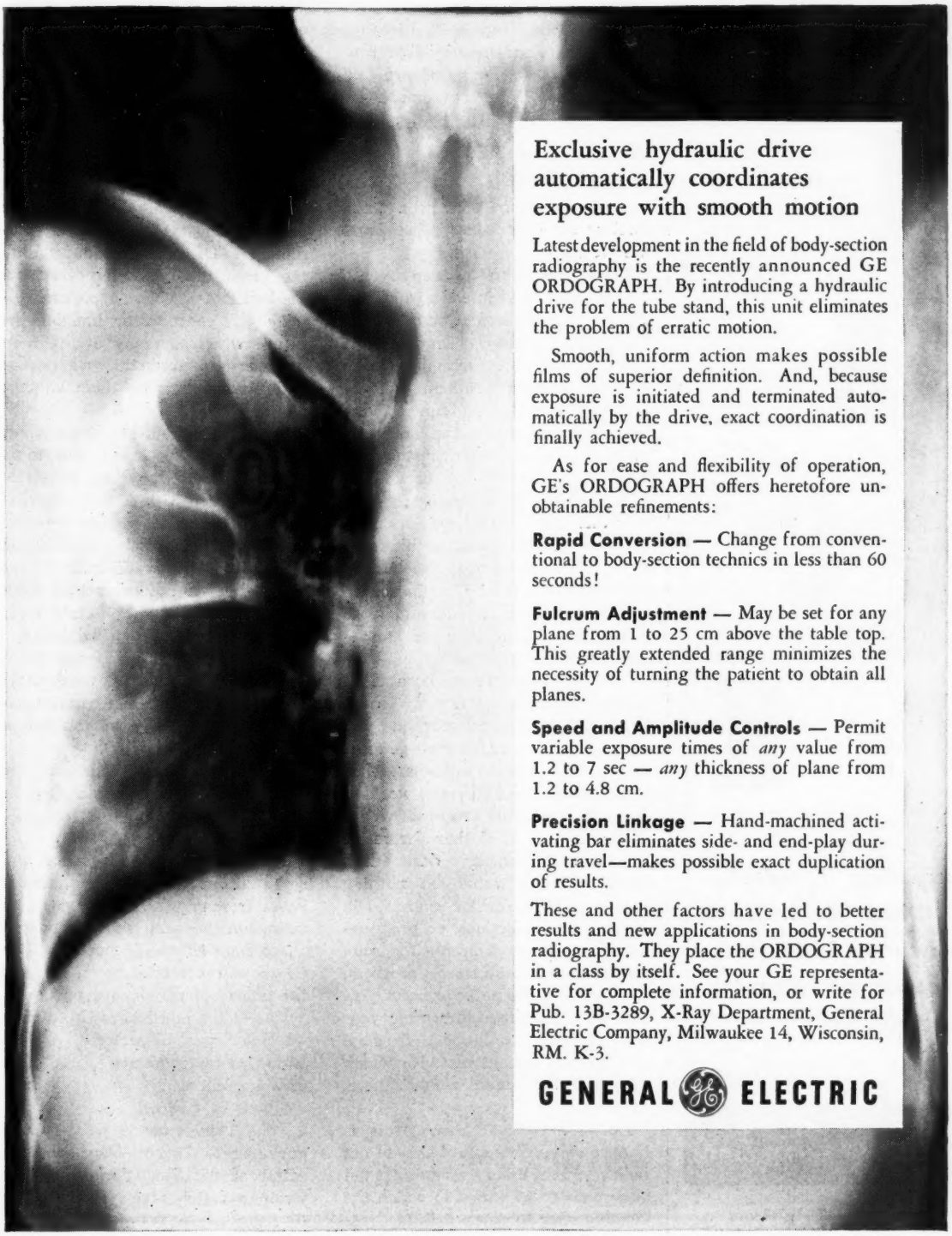
body-section radiography, the GE ORDOGRAPH



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letters

The Blue Cross "Predictions for 1952" by Mrs. Virginia M. Liebeler, on page 70 of the January 1952 '**hm**' have brought a flurry of pro and con replies. Here are some:

Fostered by skepticism of skeptical age

■ TO THE EDITOR: Your little "Predictions for 1952" about Blue Cross are wrong.

They have been fostered by the skepticism of a skeptical age. They do not apply except to isolated shadows of reality. They suggest that nothing can succeed so long as one isolated problem can be found to permit of our minds making sweeping generalizations. All minds, Virginia, whether they be men's or children's, are capable of such careless preoccupation.

In this great universe of ours, man is a mere insect, an ant, in his foresight, as compared with the boundless world about him, as measured by the intelligence necessary to grasp the whole of truth and knowledge of things to come.

Yes, Virginia, there is a Blue Cross. It exists as certainly as the legions that subscribe to it, and you know that its benefits give genuine help to the health of millions. Alas! How dreary would be the world if there were no Blue Cross! It would be as dreary as if there were no Virginias forecasting dark days ahead. There would be nothing about which to fashion exercises in fantasy, no predictions, no prognostication to make tolerable the routine of Blue Cross's steady progress. We should have no enjoyment, except in witnessing year after year that Blue Cross is here to stay. The eternal divinations with which oracles fill the world would be extinguished.

Not believe that Blue Cross is here to stay! You might as well not believe in anything. You might get your papa to hire men to watch the country over to catch a Blue Cross Plan in the throes of a problem, and even if they did see it, what would that prove? Nobody is perfect, but that is no sign that Blue Cross is on the verge of collapse. The most real and abiding things in this world are those that grow to maturity in spite of adversity just as Blue Cross has done and will continue to do.

Did you have all the facts before compounding your capsuled predictions? Of course not, and there's the proof that your forecast lacks the luster of objective appraisal. Nobody can conceive or imagine the future when so many of the facts necessary to predict it are unseen and unseeable from their vantage point.

You may take Blue Cross apart from where you stand and think you see something wrong, but there is much more to it that you cannot perceive or expect to grasp unless you know as much of Blue Cross as all the people working in it have learned in all the years they have worked in it together. Only faith, energy, devotion to principles, and sincerity of purpose of the well informed can push aside the curtain and view with even a remote degree of certainty what the future holds for Blue Cross.

Is Blue Cross here to stay? Ah, Virginia, in all this world there is little else so abiding.

No Blue Cross?

Thank heavens, it lives and will serve faithfully always. A thousand years from now, Virginia, nay, ten times ten thousand years from now . . so long as people need it, Blue Cross will continue to make glad the hearts of people everywhere.

Richard M. Jones,
Director.
Blue Cross Commission,
Chicago, Illinois.

P.S. This letter is written with apologies to Charles Dana, onetime editor of the *New York Sun,* who wrote a letter about Santa Claus to a girl named Virginia.

Congratulations on courageous action

■ TO THE EDITOR: You have made a thoughtful analysis of "The Peculiar Situation" in your *Predictions for 1952*. Our congratulations.

Let us congratulate you, too, on a courageous action. I fear there will be some lads around the country who will have very little liking for what you say. But somehow, I suspect you aren't too worried about that.

While I thoroughly appreciate your entire article, I got so very much from the excerpt from the Yale professor's speech made in 1883.

Keep up the good work! For surely, here and there a seed is planted, and many of them will grow and produce results.

[NAME WITHHELD BY REQUEST.]

With reference to Blue Cross in '52

■ TO THE EDITOR: I would like to call your attention to page 70 of your January, 1952 issue of HOSPITAL MANAGEMENT which has reference to the news of voluntary health plans, and to the sub-heading "Predictions for 1952" by Virginia M. Liebeler.

We have always welcomed constructive criticism, as I am sure all Blue Cross Plans do, but we believe the points made might be quite misleading without a full consideration of the facts.

For instance, referring to footnote 2 of the article, the facts are that subscribers in groups in the Minnesota Plan receive a 70-day contract and when they leave the group they receive a 21-day contract.

In 1935 a Blue Cross subscriber paid $9.00 per year and for dependents an additional $1.00 per year. The subscriber was entitled to 21 days hospital care in a three- or four-bed room or $3.00 a day toward more expensive accommodations; operating room, anesthesia, surgical dressings, and limited laboratory, drugs and x-ray services. Fifty per cent of these services was allowed for maternity care. Dependents were entitled to twenty-five per cent of the above benefits.

Psychoses and pulmonary tuberculosis cares were excluded.

A subscriber at that time was required to be employed in order to be eligible for renewal of this contract.

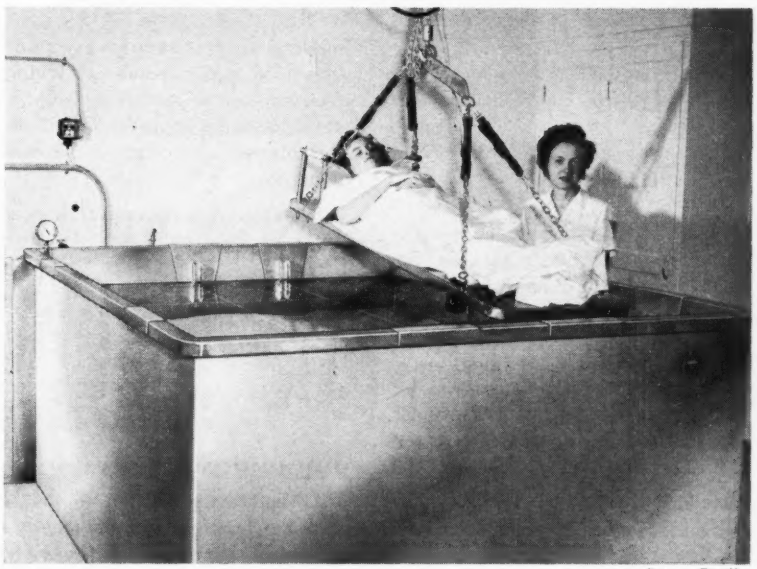
Since the Minnesota Blue Cross Plan was specifically mentioned in Mrs. Liebeler's critique it might be only appropriate and fair to mention that:

1. We have an outstanding, capable board of trustees and an excellent executive staff, who, in my opinion, know their business.
2. We have the services of one of the outstanding actuarial consulting firms in the country.
3. We have the full support and the cooperation of the Insurance Department of the State of Minnesota, which in addition to our consulting actuaries advised of the needed rate increase in relation to

continued on page 126

There are two times . . when a hospital purchasing agent should *not* speculate: (1) when he can't afford it, and (2) when he can.

Practical Answer for Muscle Re-education



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"...to talk of many things"

Lessons in humility

by **E. M. Bluestone, M.D.** Consultant • Montefiore Hospital • New York City

■ WE HAVE IN OUR HOSPITAL the kind of patient who knows more about his illness than the doctors ever will. "Don't ask the doctor, ask the patient!" is an old saying which still holds good.

Irving . . has been occupying a room in our private pavilion for some time with a diagnosis of multiple sclerosis. He has all the classical signs and symptoms of the textbook description of this disease, yet he is one of the most cheerful and optimistic patients in our hospital. He is quite expansive and will stop any man who passes him in the corridor to find out, first, whether he is a doctor and, if he is, what he knows about multiple sclerosis.

We have, as you are aware, a strong teaching affiliation with the College of Physicians & Surgeons of Columbia University, and we do, indeed, most of the undergraduate and all of the graduate teaching in neurology for that school. Irving has been demonstrated to successive classes on many occasions and, in the most recent instance, he amused the students by knowing more about the disease than the professor, who was demonstrating him to the class.

Dr. Theodore J. C. von Storch, full-time chief of division in our hospital, holds the rank of professor of clinical neurology in Columbia University. He made an exceptionally good presentation of Irving's case and not only outlined his signs and symptoms in great detail, but also quoted authority as he went along.

"AND I QUOTE . . . . . ."

Quotation marks in printer's ink
Reflect a world of worth;
They credit those who work and think
And give ideas birth.

—E. M. BLUESTONE, M.D.

He had every reason to believe that he had done well and was therefore surprised and somewhat embarrassed when, at the end of his presentation, Irving piped up, in the characteristic s c a n n i n g speech of multiple sclerosis, "Doctor, you-for-got-to-tell-them-about-one-of-my-symp-toms."

Somewhat taken aback, the professor said, "All right, Irving, what did I omit?"

"You-for-got-to-tell-them-that-I-am-eu-pho-ric!"

I am sure that the syndrome of multiple sclerosis is now well fixed in the minds of these students.

Flunked . . We have, as you may have heard, a museum of neurological material in our hospital. Much of it is used at the Columbia Medical Center in the periodic examinations which the American Board gives to applicants for certification in neurology.

In a recent occurrence one of the candidates was particularly rough with Irving. He was, in fact, so unkind to him that Irving decided to confuse the examiner by responding erratically to the testing of his reflexes. As a result the Rombergs and the Babinskis proved untrue to the men who named them and the candidate was out of luck. Irving was quite right in claiming afterwards that he had "flunked him cold."

X for Xenophon . . We have a lot of fun with names in our hospital. In dealing with a polyglot patient body, and with occasional students from distant realms, we run across names that are intriguing if not funny.

I recall the case of Harry X. Cohen who applied for internship in our hospital. At the start of the required routine interview I asked him what the X stood for and he replied "Xenophon." I made it p l a i n that I considered Harry Xenophon Cohen a rather odd combination of names and sought the explanation, which he was only too eager to give.

He said that when he enrolled at the College of the City of New York there were six Harry Cohens in his class so that the dean decided to give each one of them a middle Greek name to distinguish him from the others. Harry drew Xenophon.

Excerpt from a letter addressed to members of the Hospital Administrators Correspondence Club April 23, 1951.

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Bradford Hospital, Bradford, Pa.
Architect: Thomas K. Hendryx

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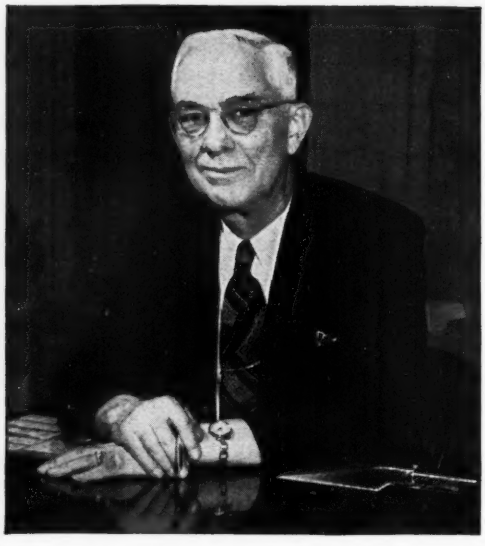
Aluminum Window Manufacturers Association
74 Trinity Place, New York 6, N. Y.

Dr. Ferguson's mailbag

Have you a medical audit?
If you have a medical audit in your hospital please send forms used and opinions to me at American College of Surgeons, 40 E. Erie St., Chicago 11, Ill.



Hospital standardization problems and answers

Dr. Paul S. Ferguson, who has succeeded Dr. Malcolm T. MacEachern as director of the hospital standardization program of the American College of Surgeons, and who will continue the work of answering hospital standardization questions on this page

■ PROBLEM: A representative of a county medical society writes, "May the monthly staff meetings of two local hospitals having open staffs be held in succession following the evening meeting of the county medical society?"

■ ANSWER: It would be inadvisable to attempt this plan since experience shows that "double heading" staff meetings never afford the necessary opportunity for the thorough review and analysis of the clinical work of the individual hospital. There is a tendency to rush through the meetings as quickly as possible when held in this manner and they become perfunctory, complying with the letter rather than with the spirit of the requirements of Hospital Standardization. Each hospital should continue to hold its monthly staff meetings in its own institution and independent of other types of meetings. ■

■ PROBLEM: A hospital superintendent writes, "After a patient has expired, or a victim of an accident is brought in 'dead on arrival' or expires before a doctor can be reached, is it necessary that a doctor officially pronounce the patient dead, even in the wee hours of the morning?"

■ ANSWER: After a patient has expired it is necessary that a physician officially pronounce him dead even though death occurs during the night. Notations should be made in the deceased patient's record, usually in the progress notes, of his death, the time, and signed by the physician who pronounces him dead. A death certificate, authorization for delivery of the body to a mortician, and the mortician's receipt are necessary parts of the recorded transactions. If an autopsy is performed, a protocol should be made a part of the medical record.

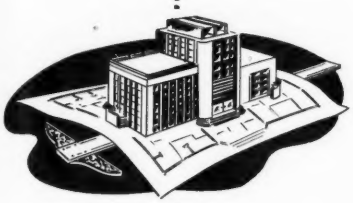
When a body is brought in from the outside in an emergency, that is, dead on arrival, or a victim of an accident expires before a doctor can be reached, a doctor should be called in to attest the death, the same as in other cases. Ordinarily, either of the foregoing would be a "coroner's case" and the coroner should be notified accordingly. Records similar to those outlined above should be kept. ■

■ PROBLEM: An administrator writes, "When a patient expires and the body is removed, what records should the hospital keep, showing removal of the body and who should sign these records? Should these records be part of the chart?"

■ ANSWER: The body should be delivered to the undertaker upon receiving written authority from a responsible relative or friend and the undertaker's receipt for the body must be secured. Many hospitals include the receipt, authorization for removal and the death certificate in the medical record while others keep them in a separate office file. ■

March • 1952
hm
Hospital Management

by Henry X. Jackson Administrator
Marin General Hospital • San Rafael, Cal.



Problems of the pre-opening program: planning, building and equipping

■ RESPONSIBILITY for most of the problems connected with the planning, building and equipping of a new hospital can be traced to a very few sources: the governing board, the architect, the consultant, and the administrator. Where the responsibilities of each are recognized and fully met, and where there is an intelligent integration of their activities, the problems are few; where such understanding and integration are absent, they may be many.

Most important responsibility . . is that of the board, to conduct or have conducted a complete survey of the hospital needs of the community, not only to determine the over-all number of beds required but to pinpoint as closely as possible the distribution of these beds to the various services.

Most of us know at first hand the impossible operating conditions which arise from a haphazard or incorrect assessment of bed needs when the population, its character, proximity to other hospital facilities, or any of the other complex factors involved, precludes that degree of utilization which enables an institution to operate efficiently. We know, too, of hospitals in which the medical and surgical floors are filled beyond capacity while maternity and pediatric beds lie empty. Since few boards are sufficiently experienced to conduct such a survey, I strongly recommend that expert services be engaged for this purpose.

Funding . . Having determined the nature and scope of the hospital program, keeping in mind future as well as present requirements as indicated by population growth, industrial expansion, medico-scientific trends, and other pertinent factors, the board must then see that sufficient funds are on hand to provide properly for these needs. Many difficulties are due to under-capitalization resulting from improper evaluation of construction costs or from oversights in the determination of what constitutes the total cost of opening the doors.

At least three new hospitals in California are now suffering financial ills because they failed to include in their budget provision for landscaping costs, adequate equipment and supplies to begin operations, and salaries of personnel necessary to prepare for opening day. These salaries will usually approximate one-third to one-half of the projected monthly payroll. Provision must also be made for the inevitable deficit incurred for whatever period of time elapses from 0 per cent occupancy to the 75-80 per cent necessary for "breakeven" operations.

Adequate funds having been assured, the principal remaining responsibility of the board is the selection of competent people to implement the program: architect, consultant and administrator. Every effort should be made to select an experienced hospital architect, one who understands that the end result must be not only architecturally and aesthetically correct but functional as well.

Simultaneously the board should engage the services of a consultant to work with the architect in the functional planning of the building. The board should select its administrator as early in the program as possible, certainly before the purchase of equipment and supplies.

While it would be ideal for the consultant ultimately to become the administrator, such an arrangement is rarely possible. A common pro-

This paper was delivered November 8, 1951 before the hospital conference of the Clinical Congress of the American College of Surgeons in San Francisco, Cal.

cedure is to engage the services of the consultant until the construction contract is let and then to hire an administrator to equip and supply the hospital and to act in a liaison capacity between the board and those directly involved in the construction program. The employment of a clerk-of-the-works (building inspector) recommended by the architect completes the primary responsibilities of the governing body.

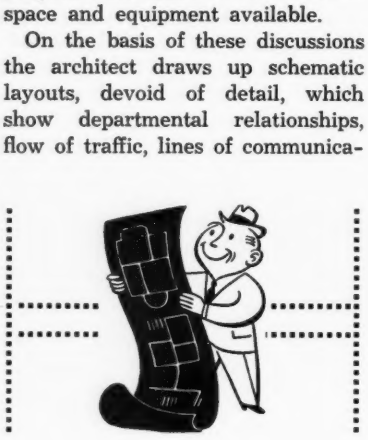
Choosing the site . . From time to time there will of course be construction matters which require board action. If the governing body is large, a building committee will often streamline the procedure by which decisions on these matters are reached. The first such decision is that of site selection. All of the many factors entering into this selection must be carefully evaluated . . accessibility to patient population, both by car and by public transportation, proximity of water and other utilities, parking facilities, adequate room for expansion, bearing properties of the soil, nearness of labor market, housing facilities, etc.

Closely interwoven with the problem of site selection is consideration of the type of building to be constructed, i.e., whether it is to be multi-story or single story. While much can be said for both types, the results of a recent survey conducted by the Bureau of Hospitals, California State Department of Public Health, showed a preponderance of opinion favoring vertical construction in hospitals of over 50 beds.

The architect . . next proceeds to draw up sketches of the building, orienting it on the site, and presenting for board approval its general architecture and appearance. There ensues a series of discussions in which the consultant recommends location and size of departments.

It will be found helpful to have committees representing the various medical specialties to act in an advisory capacity in determining the size and location of special equipment and assisting in the solution of other problems pertinent to the conduct of their work in the hospital. Special care should be taken to insure balance lest some specialty, because of the forcefulness of its representatives, winds up with a disproportionate share of the over-all space and equipment available.

On the basis of these discussions the architect draws up schematic layouts, devoid of detail, which show departmental relationships, flow of traffic, lines of communica-



tion, etc. Several schematic drawings (19, in the case of Marin General Hospital) may have to be presented and altered before a workable set is decided upon.

The next phase is the development of preliminary drawings indicating the location of fixed equipment within the departments, electrical and plumbing fixtures, beds and built-in equipment within the patient rooms. During this period the consultant studies the operation of each department and recommends fixed equipment with a particular eye to labor-saving machinery and devices.

For example, he will conduct a survey of the laundry operation, usually with the assistance of a laundry layout expert, to determine whether the volume will be sufficient to warrant semi- or fully-automatic equipment and whether the labor savings involved warrant the additional expenditure. The importance of these determinations cannot be too strongly emphasized, for frequently it is at this stage that the whole operational picture is once and for all outlined.

Final preliminary drawings having been approved by the governing body, the architect prepares the working drawings and specifications on the basis of which bids will be submitted and the construction contract let. Again I would place strong emphasis on the need for ample time in which to check and recheck all phases of the contract documents, for the correction of errors and omissions at this stage is far less expensive than their correction by change order after the contract document has been let. Even with these precautions it is inevitable that some changes will be made and cognizance of the expense of such changes should be taken in preparing the construction budget.

Before bids are called for . . the problem of whether to let one prime contract or segregated contracts will undoubtedly arise. Here is a moot question indeed!

The proponents of segregation claim that significant savings can be realized through the elimination of the prime contractor's overhead and profit on those phases let separately. They also hold that, where fixed equipment is purchased directly by the owner and installed by the contractor or subcontractor, hundreds of dollars can be saved through the elimination of markups on the cost of such equipment.

Those who favor one prime contractor claim that these savings are more apparent than real and that in any event the difficulty and expense of coordinating and integrating the subcontractors' work far outweigh any savings which might be inherent in segregated bids.

It is the writer's opinion, based on extensive research and discussions with construction estimators, that the best interests of the owner are served when one prime contract is let, which includes the purchase and installation of all fixed equipment, excluding x-ray. While this is impossible to prove, I am convinced that, when fixed equipment is excluded from the contract, the subcontractors' expense of installation and profit is reflected in higher basic bids.

Duties of administrator . . Once the contract is let, the board should engage the services of both the administrator and the clerk-of-the-works. The administrator acts as the direct representative of the owner, often being given authority to make on-the-job decisions for them within certain prescribed limitations. He reviews and makes recommendations to the board on all change orders prepared by the architect.

His is the responsibility for the selection and procurement of all equipment and supplies needed to open the hospital. In this regard the advice and recommendations of committees of the medical staff and department heads of other hospitals (his will usually not be on the job in time) will be of invaluable assistance. Here again departmental function must be studied to determine where labor-saving devices might be installed. For example, machine bookkeeping may eliminate one or more persons from the payroll; an automatic dishwasher for the laboratory may result in the saving of costly man hours.

The administrator must also function as the director of public relations, ever alert to newsworthy stories concerning building progress, new equipment, contributions, etc. He must schedule the reporting dates of key personnel and budget for their salaries, allowing ample time for departmental organization and staffing, but avoiding unnecessary payroll expense.

Important, too, is his task of preparing the first year's budget and establishing the hospital's rate structure. Competent legal counsel should be available to him, for many of the problems encountered are fraught with legal implications.

The clerk-of-the-works . . or building inspector, acts as the owner's agent in ascertaining that the hospital is built exactly to plan and specification. Though in the employ of the owner, he is under the direction of the architect. No authority is given him to make decisions or changes on the job without the consent of the architect.

The clerk-of-the-works inspects all incoming materials and is empowered to reject any which do not meet specification. Deviations or irregularities are brought by him to the attention of the architect. Rigid adherence to this chain of command . . contractor or inspector to architect to owner . . is an absolute "must" if serious trouble is to be avoided. The board or its representative should NEVER act directly on any suggestion from the contractor or subcontractors without first clearing through the architect. Therein lies a "happy" job!

Tripler Memorial Hospital . . Honolulu, T.H., is said to be the largest in the world

Traditionally the clerk-of-the-works also maintains a daily log in which he charts the weather, job progress, labor conditions, and other pertinent data, all of which he summarizes weekly for the edification of the board.

Other architect responsibilities are: 1 . . Supervision of the construction program; 2 . . preparation of all change orders; 3 . . certification of all payments to the contractor; 4 . . interpretation of the plans and specifications; 5 . . approval of substitution of materials and equipment.

In this latter regard I have more than once been grateful for the clause in the specifications which reads: "The owner reserves the right to be the final judge as to whether or not materials or equipment meet the specifications as submitted." This wording permits the exercise of strong preferences where the low bidder's equipment is known or believed to be less desirable than that of his competitors. The final responsibility of the architect is the execution of his certificate of approval.

Public relations . . It must be kept in mind throughout all of the preopening program that the hospital, to be successful, must enjoy the good will and support of the community it is designed to serve. Routine progress reports to and through the press can do much to create the acceptance we all seek.

With proper encouragement local service clubs and women's groups will contribute thousands of dollars' worth of furnishings and special equipment, which might otherwise be impossible to obtain. Typical of such contributions made to the Marin General Hospital are a Drinker respirator (iron lung), a premature infant air lock, a movie projector and children's film library for the pediatrics service, library cart and books, flag and flagpole, and furnishings for all the public waiting areas.

More important than the dollar value of the contributions, however, is the broadened base for understanding and support which results from the participation of these people in the affairs of THEIR hospital. As early as possible an auxiliary should be formed, the members of which will act as ambassadors in telling the hospital's story. A well-designed program for informing the "speakers bureau" of the group will do wonders in creating community acceptance.

Full speed ahead advised . . Truly these are difficult times in which to build. Government con-

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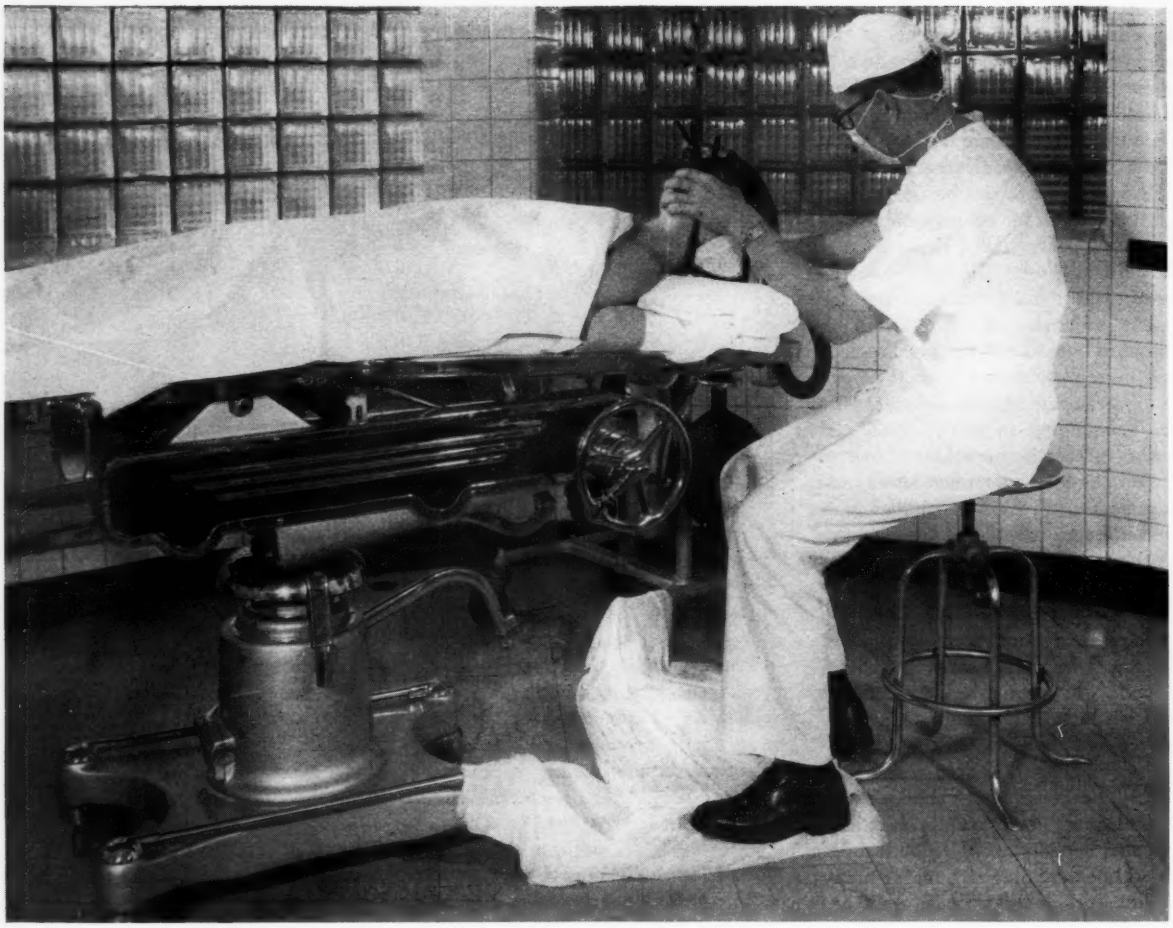


Large, wet towel . . acts as intercoupler between metal base of operating table and leg of anesthesia apparatus

Mines bureau reports ways to curb operating room explosion danger

■ SIMPLE AND PRACTICAL methods for preventing accumulations of static electricity in hospital operating and delivery rooms, thus lessening the chances of anesthetic explosions, are described in a Bureau of Mines report made public by Secretary of the Interior Oscar L. Chapman.

Origin and scope . . A series of explosions in Eastern hospitals in 1948, some of them fatal to patients (see also February, 1952 HOSPITAL MANAGEMENT p. 70), caused the bureau to launch a thorough study of operating- and delivery-room explosion hazards. The report just released describes conditions found during this study and lists suggested corrective measures. It is based upon intensive research at 14 hospitals, selected as representative with respect to size and types of operations performed.

Unlike power electricity, static electricity "builds up" on materials which do not carry power electricity. When the accumulation of static electricity becomes sufficiently great, a spark may result. While harmless from a shock standpoint, this spark of static electricity sometimes is sufficient to ignite explosive atmospheres created by the use of anesthetics. The bureau's research is aimed at preventing anesthetic explosions by erasing conditions that permit creation and "buildup" of static electricity charges.

Recommendations . . in the bureau's report range from such simple devices as spreading wet towels on the floor and letting them touch the bases of operating tables and anesthesia machines, to far-reaching changes in equipment and furnish-

ings and the exclusive use of cotton uniforms and gowns by all persons on duty during the administration of anesthetics. Tests confirmed that synthetic fabrics have a strong tendency to "manufacture" static electricity.

There probably is no combination of equipment and activity anywhere more likely to produce dangerous charges of static electricity than that found in the anesthetizing areas of most hospitals of the nation, the report says. When conditions are favorable, the static sparks become intense enough to ignite gases or vapors escaping into the room air . . and an explosion results. Many of the mixtures used for anesthesia are rich in oxygen and are easily ignited by static sparks of low energy.

Although the interest of the Bureau of Mines in the explosibility of anesthetic gases is not new, the most recent study centered largely on the nature, prevalence, and danger of static electricity where anesthetic gases are administered to patients.

Dozens of tests were made under varying conditions in a total of 78 operating rooms, 22 delivery rooms, and 16 typical hospital corridors. Floors, tables, rolling equipment, shoes and clothing of employes, blankets, towels . . all were tested to determine their relative safety. If they tended to build up charges of static electricity, they were labeled as unsafe.

Startling disclosures . . resulted from the study. It was proved that an operating table can collect a charge of static electricity when a sheet is removed from the rubber-covered mattress. In one case, speedy removal of a sheet from a mattress indicated a charge potential of no less than 9,000 volts.

While a static electricity charge of 9,000 volts would cause only a slight stinging sensation to a person, its spark could ignite an explosive mixture in an operating room, the bureau reported. Several carriages drawn along a delivery-suite corridor of a hospital acquired dangerous charges of static electricity just from the rolling of the tires.

Another carriage acquired a dangerous charge when its rubber-covered mattress was rubbed either with a sheet or a woolen blanket. However, the charge failed to develop if the carriage was touched (grounded) during the charging by a person wearing leather-soled shoes. When a sheet or a blanket was taken off the carriage and tossed on a rubber-footed metal stool, charges of static electricity were transferred to the stool.

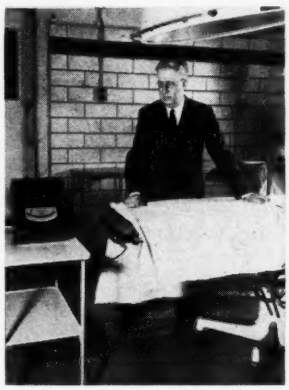
Various grounding methods . . were tested. One table was charged to a potential of 5,000 volts by removing a sheet or blanket. Illustrating a simple grounding method (suitable for use where conductive floors have not yet been installed), when a wet towel was placed on the floor with the end draped over one of the casters, the voltage indicated was zero.

A total of 150 tests were made on operating- and delivery-room employes under different conditions, either while walking or simply scuffing around, or even rising from a stool covered with artificial leather.

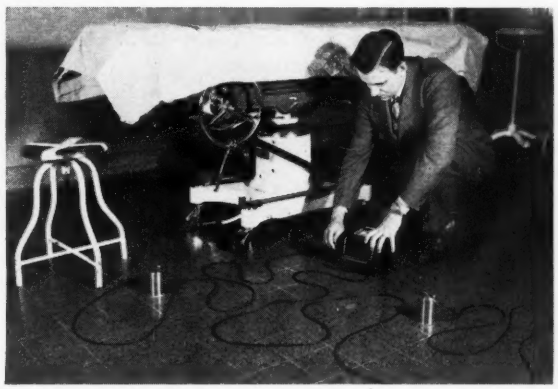
One person with rubber shoes, walking on a linoleum floor, developed a charge potential of 1,500 volts . . enough static electricity to ignite an explosive mixture. A person wearing a woolen suit, rising from a stool covered with artificial leather, also created a dangerous charge of static electricity.

The bureau's report thus suggests that floors, rubber shoes, covers, and other materials be made conductive so creation of static electricity will be avoided. Cotton was found to be the best material for uniforms.

Containing many graphs, charts, and photographs, the report offers ten specific recommendations for improving safety and reducing explosion hazards in operating and delivery rooms where anesthetic gases are used. ■

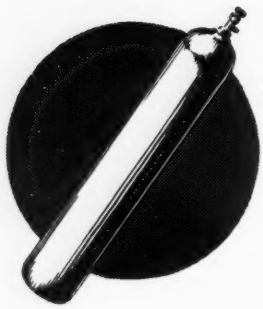


Lurking danger . . Many doctors and nurses are unaware of the potential danger involved in simply removing a sheet from the rubber mattress of an operating table. Bureau of Mines tests showed this produces an electric charge of 9,000 volts, sufficient to ignite gases



Technician tests floor . . for any resistance to electricity, during comprehensive survey of equipment, floors and clothing of personnel in 14 hospitals for static electricity. A conductive floor acts as a reservoir for static sparks, diminishing explosion risk

A free copy of Report of Investigations 4833, "Static Electricity in Hospital Operating Suites; Direct and Related Hazards and Pertinent Remedies," can be obtained by writing the Bureau of Mines' Publication-Distribution Section, 4800 Forbes Street, Pittsburgh 13, Pa. The report is reviewed in this issue on page 88.



Scouting out extra gas cylinders saves scarce metal, serves safety

■ TONS AND TONS of valuable metals . . high alloy steel, brass and chromeplate . . are lying useless in hospitals in the form of idle cylinders for medical gas (and the valves with which they are equipped). Unless these cylinders are sought out and returned to circulation, it will be necessary to throw large supplies of vital metals into the manufacture of new cylinders and valves to meet the ever-increasing demand. Without being aware of it, the majority of hospitals in this country are contributing to this situation.

Added attractions . . Several incidental benefits accrue to the hospital which takes an interest in this matter.

Unnoticed fire hazards and other unsafe conditions will be brought to light. Many unemployed dollars of inventory will be released for better use. A real contribution will be made to the metals conservation program and to the prevention of future supply problems.

One hospital administrator, for example, thought his cylinder stocks were being handled efficiently until he received a complaint about an accumulation of empty cylinders in a washroom. Becoming curious, he ordered a search of the entire building. At a cost of five man-hours, the inventory was reduced by more than $1,000. Additional storage and floor space was made available as a result. Ether and cyclopropane were found stored in a closet in Surgery along with oxygen, nitrous oxide, dressings, etc. . . a hazardous condition that was of course promptly corrected. Thereafter, responsibility for the inventory was delegated and a control system was established to forestall a recurrence of such a situation.

Where assets are hidden . . Some examples of the places in which cylinders have been found make interesting reading. Any hospital would be astonished and embarrassed to find any of the following conditions on its premises . . and so were the hospitals where these incidents occurred!

- Behind cartons stacked to the ceiling in a general storage room, nine dust-covered crates loaded with empty cylinders were found.
- Several cylinders were discovered in an old phone booth from which the phone had been removed.
- Many cylinders have been found attached to old anesthetic machines which had been stored away in maintenance departments, attics, closets, etc. Some cylinders have been removed from little-used anesthetic machines still equipped with a full complement of cylinders.
- In one hospital, three large cylinders were being used as hat and coat racks.
- Another hospital checked the record to find that several cylinders had been loaned to staff doctors who had overlooked returning them.
- Twelve large cylinders (worth over $30 each) were found to have been set in concrete to serve as posts for a wire fence . . too late to be reclaimed.
- Two crates of six full cylinders each were discovered in the morgue.
- A crate of full cylinders was uncovered in an attic under a pile of old mattresses.
- Busy laboratories are frequently lax in returning empties and often have an excess number.
- The elimination of all but one storage section for cylinders in Surgery released 35 cylinders.
- Excess stocks frequently turn up in closets and elsewhere on the floors where needs have not been carefully analyzed.

Suggestions . . While administrators may think that cylinder stocks are efficiently handled and that no hazardous storage conditions exist, the reverse is probably true. A thorough investigation of the hospital will probably disclose one or more of the conditions described above.

It is an excellent idea to have a copy of the National Fire Protection Association Pamphlet No. 56 (1951 edition), entitled "Safe Practice for Hospital Operating Rooms."* This is the standard for eliminating hazardous conditions.

The responsibility for all cylinders should be delegated to one individual. Instructions should be issued that the recommendations of NFPA Pamphlet No. 56 are to be complied with, that periodic checks of all areas of all buildings are to be made, and each stocking point is to be reviewed frequently to determine whether the inventory is commensurate with needs.

After investigation, delegation and regulation, the administrator will be well prepared for visits by the fire marshall and the insurance inspector. He should, moreover, have a twofold feeling of accomplishment at having discharged a patriotic duty and at satisfying a moral obligation toward the safety of patients and personnel. ■

*Available for 45c from the National Fire Protection Assn., 60 Batterymarch St., Boston 10, Mass.

The voice of Lexington hospitals: birth news takes to radio

by B. G. Newhoff • Versailles, Ky.

■ "GOOD MORNING. Hymson's 'Tots and Teens,' with everything for the baby, brings you Stork News," the pleasant-voiced announcer says each morning, Monday through Friday, at 9:15 Central Standard Time over station WVLK in Lexington, Kentucky.

"You will still be able to hear your favorite programs while you are a maternity patient at either St. Joseph's or Good Samaritan Hospital. Just call Four-two four-o-four in plenty of time and Tots and Teens will deliver a radio for your use while you are there," he explains.

A few bars of Brahms' "Lullaby" follow, the music that sets the mood for this ten minute program dedicated to new mothers and their babies in the two Lexington hospitals. Stork News, in which the hospitals have participated for six months, has been so successful in gaining listener attention and in holding it that already time for its continuance has been bought many months ahead.

"Now," the announcer continues, his voice hushed as if he were really about to enter a nursery where new babies slept, "we'll visit the hospitals and see who's new in the world today." A musical bridge indicates an interval of time. "Here in the maternity ward of Good Samaritan the nurse tells us there are five little new arrivals. We'll just go down the aisle here and read the tags on the cribs. Here is a girl weighing eight pounds, eleven ounces, born yesterday, December fifth. She is the daughter of Mr. and Mrs. Joseph Youngblood of 580 Hilltop Drive. That's in the Cooperstown section, out near the University, the veterans' housing project. Daddy's in school out there.

"Here's another girl, the daughter of Mr. and Mrs. William Lilly. She weighed in at eight pounds, twelve and one-half ounces at birth. This young lady will go home to Paris, Kentucky."

The data . . He mentions the sex, weight, date of birth, address and parents of the other three babies born at Good Samaritan since yesterday morning's broadcast.

"Let's run quickly over to St. Joseph's now," he suggests when all the data at Good Samaritan have been given. "We'll go as the old stork flies." Again there is a musical break. "That was a quick trip," the announcer declares. "All boys here."

As with the babies at the other hospital, so with those here he gives all pertinent facts. Today there were only three births to report from St. Joseph's. This was about an average day, with eight births altogether. On Mondays there are more than on the other days, for there are all those which have occurred since Friday morning's broadcast to report.

When all of the births have been announced, a record is dedicated "to all the new mothers and the new little citizens of this wonderful country of ours. And," the announcer adds, "we do hope they will enjoy their stay here in the world." Each day a different selection is played. The one chosen today is "Here in My Arms" as played by the Norman Clotier Orchestra. The music chosen for this salute to the mothers and babies is always sentimental in theme, and invariably it is played softly and slowly as befits the atmosphere of a hospital nursery, which the announcer strives by voice and manner to create.

"If you are expecting any time soon and will be at either Good Samaritan or St. Joseph's and would like a radio to listen to while there, just call," listeners are reminded just before the concluding commercial. This offer of a radio is the emphasized feature of the program.

Playing no favorite, Stork News starts off one morning naming new arrivals at St. Joseph's; the next those at Good Samaritan come first. This alternation is continuous. If one hospital came first on Friday, the other precedes it on Monday next.

Commercials . . At the sponsor's order, commercials are kept at a minimum. He won the hospitals' cooperation by pointing up the public service aspect of Stork News, which was his own original idea, and minimizing the commercial to such an extent that it never is an intrusion. Commercials are short, and deal entirely with baby things, gifts for the new arrival, clothing, books the new mother will find helpful when she takes the baby home, and articles of infant furniture needed for the nursery.

The program is based on the premise that everyone loves a baby and enjoys hearing about the new babies in town with all the details of who, what, when and where. Placed strategically next to Mutual's popular commentator, Cecil Brown, it gets his holdover audience. But one who catches it once in this way is likely to listen again from choice.

The selection of the station is a good one, too, as WVLK is powerful enough to reach the entire Central Kentucky area which the two hospitals serve. About 20 per cent of the maternity patients come from

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Architects and physicians: their roles in building

by
Alston G. Guttersen
Architect
U.S. Public Health Service
Division of Hospital Facilities

This discussion of hospital architecture stresses what the architect expects of the physician. Although directed primarily to mental hospitals, these valuable suggestions are almost equally applicable to any hospital's pre-construction and construction program. . .

■ SINCE THE HOSPITAL is one of the most complex of modern buildings, the physician, the specialist, must supply information on the techniques or functions which are to be conducted within it.

In hospital planning, the architectural design must reflect medical principles and concepts. To achieve this, intimate cooperation between physician and architect is necessary. In programming and planning for hospitals, physicians and architects may have ignored each other too much, but owing to the increasing complexity of medical programs, their rapidly changing concepts and the very high cost of building, close cooperation is imperative.

(It is appropriate here to mention the various phases of procedure in the planning and construction of a project. If one understands these phases, it becomes obvious that only by the complete cooperation of the hospital board, the administrator, the consultant, the architect and the building contractor, can the success of the project be guaranteed.)

The program . . When the number of beds and types of mental health services to be offered have been determined by the hospital board, a program should be developed. In the preparation of this program there must be detailed discussion by the psychiatrist and his staff of specialists with the architect to determine the requirements for each department.

While the architect will find it necessary to discuss problems with the many technicians who operate the various facilities, all decisions must be referred to the psychiatrist who, as chairman of the program committee, must be responsible for the program. The architect cannot work for a dozen clients.

The discussions will not be concerned with the building or design, but will be confined to problems of function only. For example: must sedative hydrotherapy be near the disturbed patients' area or can it be centralized in order to save on piping? Or, can the electro-encephalograph be in the area for other diagnostic facilities or should it be in the outpatient department or near the neuropsychiatric patient area? And who is best qualified to answer the question, the architect, the physician or the technician? And what is the accepted practice?

The architect will, during these discussions, find it necessary to make freehand sketches or flow diagrams to understand more clearly the particular function which is under discussion. From these discussions a final written program will be prepared. This program will clearly state the requirements of each department of the hospital including the major items of equipment and the personnel employed in each department.

Too much importance cannot be placed on this preparatory work. If the problems are clearly thought out at this stage, much time and money will be saved and a better hospital will result.

(After briefly mentioning the remaining phases, I shall return later to a more complete discussion of the program phase.)

Schematic phase . . After the program is complete, the architect may proceed with the next, or schematic, phase. At this time he will translate the program information into terms of the proper relation, and traffic flow, of the departments; and of the units within these departments; and the area required for each.

From this study or translation, and for the first time, the size and shape of the hospital will evolve. If the staff of specialists has clearly stated and explained the requirements in the program, they will be gratified to find the proper arrangement, and relation to each other, of all elements. If not, much work on their part and on the part of the architect must be re-done, and the schematics altered to fit the requirements.

This is a difficult procedure, and, in a complex hospital building, may be impossible, so that a fresh start must be made.

After the schematic drawings have been reviewed by the staff and approved by the physician, a fairly accurate estimate of cost can be made. If the amount is acceptable, the architect may begin with the next, or preliminary working drawing, stage.

Preliminary working drawing phase . . In this stage, the architect and his structural, mechanical and electrical engineers study the most practical, economical and satisfactory way to meet the various engineering problems. They will also develop larger scale drawings which show major items of equip-

ment. Some changes may develop as a result of this more detailed study, and the architect should give all concerned ample time to study the drawings and make any necessary changes.

During this period all thinking should be clarified or crystallized in the form of these larger scale preliminary drawings. After approval of these preliminary working drawings, no major changes should be necessary. The architect can now, with certainty, proceed with the development of the next (working drawing and specification) stage.

Working drawing phase . . The function of the working drawings is to convey to the contractor and to his workmen all details pertaining to the construction of the building. All drawings must be to accurate scale and include all information that may be more comprehensibly presented by drawings, rather than by specifications. A complete set of working drawings will be divided into architectural, structural, mechanical and electrical. The specifications supplement the drawings, prescribe qualities of material and workmanship which are to be furnished, and include all information which is not shown on the drawings. They include, or describe, the legal forms which are to become a part of the contract.

Construction phase . . After award of the contract and during the construction of the project, the architect generally supervises the work. Since he has prepared the plans and specifications and is thoroughly familiar with the work to be done, he is most competent to supervise the construction. On larger work the owner may hire a superintendent who should be selected by the architect, and who will spend his entire time on the project under supervision of the architect.

Dealing more specifically with what the architect expects of the specialists, brings us back to a discussion of the preparation of the program. I should like, at this time, to quote a member of the psychiatric profession, Doctor Paul Haun, who has had an unusually large experience in the responsibility of guiding a large hospital construction program. He referred to this phase as the "criteria" and has stated the importance of this work as emphatically and as well as I have ever seen it written.

He said, "I know of no other item in planning that can contribute more to the success of a building program than perfectly organized, meticulously compiled and compulsively accurate written criteria. The development of such a document is

a devastatingly protracted task which will tax the patience of every participant and will rise to haunt the dreams of any contributor who thinks hospitals can be built by magic and not by sweat and thought.

"The simple logic of discipline by criteria is overpowering. If the doctor, the architect or the engineer do not know what they want, there is no genie who will leave it on their doorstep. Unless the architect has precise information on requirements before he sharpens his pencil, he will be harried to exhaustion by second guesses, afterthoughts, vacillations and assurances that everyone should know such and such a room is only 'half as large as necessary'."

Now possibly everyone else knows that, but how frequently is an accurate and complete program compiled for the architect?

Tradition's dead hand . . Is it not all too often that the architect is provided with a list of mental hospitals to visit for information on building requirements, with little or no information on functional requirements? Is this good enough? Were not most of our mental hospital buildings, which comprise our precedent for design, built previous to the use of newer, more scientific medical treatment programs, and programs in recreation, in occupation or even relaxation? True, we can and do adjust ourselves to buildings, and revise our methods of procedures within them, so at times they seem satisfactory; but have we analyzed the functional requirements in an effort to determine if a more efficient arrangement could be devised in new construction for our newer techniques?

I know of a new building which is under construction which is to house 100 chronic disturbed patients. The building is divided into four nursing units of 25 beds each, and 60 per cent of the beds are in single rooms. The largest bedroom contains six beds. Each nursing unit has two living rooms and every living room opens directly to separate outdoor areas for programs of recreation or relaxation when not under a scheduled specific therapy. In addition, there are the medical treatment areas and rooms for occupational therapy. An exercise gymnasium is provided and this also opens into an outdoor area.

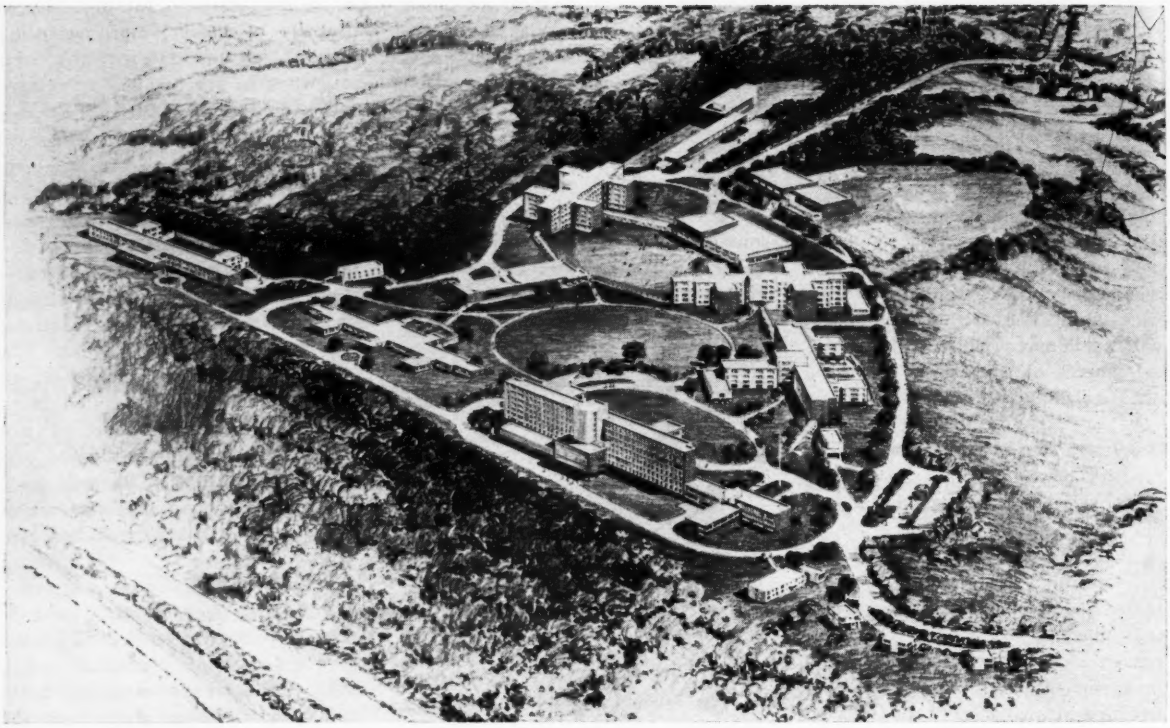
At the same time, at another hospital, there is a building under construction which is to house approximately 125 ambulant older women patients, all of whom are to live in one large room. In answer to a question concerning the need for this, it was stated that all patients were suicidal.

Other examples . . Another building under construction, at another hospital, provides for the building of the fourth side of a quadrangle which was conceived many years ago. Occupational and recreational therapy facilities were included in the new construction, but all were in basement areas as it was impossible to provide them in more accessible locations and still retain the shape and size of the original design.

Still another example: A receiving building for a state mental hospital, which is near a large city, has a separate wing of offices for physicians, psychiatrists and psychiatric social workers for outpatient services and follow-up care; examina-

continued on page 155

The subject matter of this paper was presented at the round table discussion on hospital architecture at the 1951 annual meeting of the American Psychiatric Association.



Artist's aerial perspective . . of the Neuropsychiatric Hospital of the Veterans Administration on a riverside hilltop at Pittsburgh

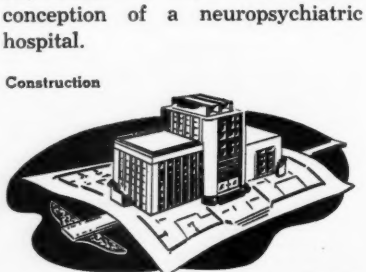
V-A builds $16,000,000 mental hospital in Pittsburgh with special features

■ NEARING COMPLETION in Pittsburgh is a new hospital, one of the largest to be erected since the war, and one that will undoubtedly introduce many interesting and important innovations in the field of hospital design and construction. Designed by Alfred Hopkins & Associates of New York, in conjunction with Prack & Prack and Bowers & Barbalat, architectural firms of Pittsburgh, it is the Veterans Administration Neuropsychiatric Hospital of Pittsburgh. Built at a cost of $16,000,000 and containing 1,270 beds, it comprises 14 buildings, most of which will be constructed of concrete with brick walls, on a site of 225 acres.

Convenient location . . The site of the hospital is a hilltop overlooking the Alleghany River, just within the city limits, combining necessary isolation and quiet with city convenience. City utilities and the city mail system are utilized, and easy accessibility makes the hospital especially attractive to doctors. As an added advantage, patients who are permitted to leave the hospital have the activities and advantages of a large metropolis at hand, while the families and friends of patients will find the location convenient, too.

Careful planning, with efficiency and economy always in mind, has resulted in a hospital that is highly efficient, easy to maintain, and . . despite its size . . remarkably cheerful, unlike the usual rather grim conception of a neuropsychiatric hospital.

Construction

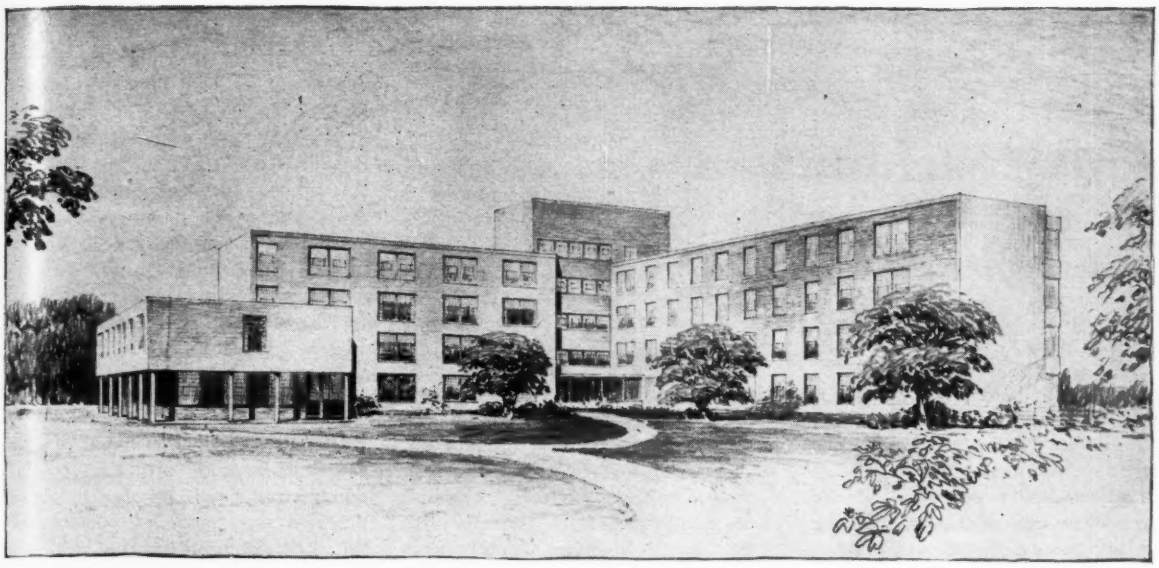


Feature

Main building . . of the hospital will be a six-story, 240-bed general medical and surgical building, containing among its facilities four operating rooms and auxiliary facilities, two psychiatric wards, and the administrative offices. Other buildings will provide facilities for continued treatment and occupational therapy, recreation, housing for nurses, interns, attendants and other personnel, etc.

There will also be a gymnasium, swimming pool, library and chapel. A series of underground walks and tunnels will connect all 14 buildings. Air conditioning will be provided in operating suites, surgical recovery wards, the allergy suite and seclusion rooms. For easy communication, and for sending materials to the laboratories for study or analysis, pneumatic tubes will be used.

Ease and economy of maintenance were also kept in mind when the hospital was being designed. For



Admission and Treatment Building . . of the Veterans Administration Neuropsychiatric Hospital now under construction in Pittsburgh, Pa. This structure is visible at center right in the over-all view on the preceding page. Under direction of Corps of Engineers, U. S. Army, the hospital was designed by Alfred Hopkins & Associates, N.Y.C., with Prack & Prack and Bowers & Barbalat, Pittsburgh firms

this reason, corridor ceilings, which conceal pipes, are made of demountable, acoustically treated steel or aluminum sections which need never be painted. Thus, when pipes need repair, it doesn't mean taking down the entire ceiling.

Throughout the hospital the comfort of patients is the primary consideration. In place of the old ward housing large numbers of patients, the new four-bed ward is being used. An interesting innovation is the removal of corner projections in the rooms, so that window frames are flush with the side walls, eliminating dark corners and admitting more sunlight. Elimination of these projections also provides patients with a broader, more attractive view, and allows more floor space.

Fenestration . . The windows themselves are one of the hospital's most important innovations. Large and well-spaced, they overcome problems formerly posed by windows in psychiatric hospitals. Four "layers" were necessary: an interior screen to prevent a disturbed patient from smashing the window, the window itself, an exterior insect screen, and, of course, the inevitable grim bars, which did so much to depress the patient, often causing him to associate the hospital with a prison. Furthermore, it was nearly impossible to clean such windows, and, as they collected dirt, they cut off the sunlight, making the room dark and depressing.

New psychiatric window . . first used in this structure . . was built by the William Bayley Co., saved $80,000 in extra screens

Thorough research and careful planning resulted, however, in a new "psychiatric window" which eliminates the extra protective layers and permits the windows to be cleaned easily from the inside or the outside. It was developed by engineers of the William Bayley Co., Springfield, Ohio.

Made of tempered glass, which is almost indestructible, it eliminates the necessity for an inside screen. Since only the central portion of the window may be opened, this is the only area that requires an outside insect screen, which may be removed readily when the windows are cleaned.

Bars have been eliminated altogether. Instead, the metal strips used to separate the panes of ordinary windows have been sufficiently strengthened to serve as a means of detention if, by some chance, a patient should succeed in breaking the glass. Since barred, dark windows are often a deterrent to the cure of a psychiatric patient, these new windows are expected to contribute to the improvement of the patient's condition. Not least noteworthy is that elimination of extra screens reduced building costs by $80,000.

Summary . . Thoughtful planning on the part of a team of experienced architects has resulted in increased efficiency at decreased costs throughout this important new hospital which, when completed, will be an important center for the care and treatment of neuropsychiatric patients, as well as for other veterans in the Pittsburgh area requiring general medical or surgical attention. ■

Northwestern inaugurates course in hospital planning and purchasing

by Laura Jackson

■ A DOWN-TO-EARTH course designed to give the future administrator practical knowledge of the physical aspects of the hospital and the purchasing problems connected therewith is being offered by Northwestern University's Program in Hospital Administration. The hospital plant itself is studied, including the relation of the design to economical maintenance and efficient service, trends in interior decorating, furnishings and equipment, and the significance of intelligent selection of materials and supplies of all types.

The ten lectures on hospital planning and construction, and six on major equipment such as boilers, laundry machinery, dietary facilities, and x-ray installations . . in other words, the type of equipment for which the architect is responsible . . are given by architects and engineers. Although not many administrators, percentagewise, are destined to have a responsible part in any major hospital expansion, all administrators will be faced with the problems of making the best use of the hospital plan which has been handed down to them and of recommending changes in that plan when it becomes outmoded.

Northwestern U. students . . from the Hospital Administration Program view an adjustable hospital bed in the display rooms of the Simmons Company in the Merchandise Mart, Chicago. The coordinator, Roy Johnson, is describing the bed's operating features

Purpose . . of this part of the course is to study principles so the administrator will be able to comprehend the significant aspects of the complex problems he will encounter in his work. It should also help him to form a rational basis for observation and interchange of ideas which will contribute to the advancement of all hospital planning. The aim is to impart firm knowledge of the complex forces behind today's planning problems, so that the students will have the key to an understanding of the factors which are changing hospital care and with it hospital planning.

The course in planning and construction accents the advantages of the collaborative approach to the solutions of problems and urges maximum utilization of the combined experience, knowledge and intelligence of trustees, professional planners, and all personnel.

Method of procedure . . in a construction project is outlined from its inception, through the preparation of drawings and specifications, through the contracts, until the final payment is made and the building is accepted as complete in accordance with the contract documents. The future administrator is given insight into the techniques employed in the preparation of the drawings, and the building laws of municipalities and states which must be observed.

Particular study is devoted to the planning of the nursing unit which is the key to the plan of the hospital. The planning of each separate department is studied, with emphasis upon selection of the proper plan, finishing and materials in

the interior components of the hospital, as well as in the building as a whole, from the standpoints of maintenance, repair, replacement, and efficient operation. Types of plumbing, heating, electric and air-conditioning systems and the mechanical system as a whole are studied in quite complete detail.

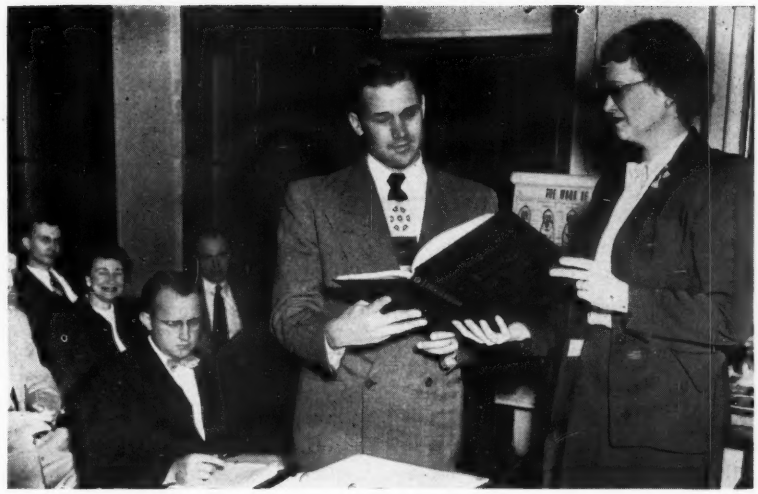
In a course usually taken concurrently, "Hospital Organization and Management," the student has ample opportunity to visit a large number of hospitals for planned demonstrations. He can therefore observe at first hand the effects of planning, furnishing, and selection of equipment upon the functioning of each separate department as well as on the hospital as a whole.

Visual aids . . Slides, films, models and charts enhance the educational value of the hospital planning and construction part of the course as they do also that of the part devoted to hospital purchasing and equipment. In the series of 16 lectures on the latter subject, many of the instructors bring into the classroom apparatus and supplies of various types for demonstration. This is supplemented by a number of trips to manufacturing plants and showrooms.

Tours . . have been curtailed in this year's schedule because it was felt that more time was involved than the student could justifiably spare from his other work. It has proved to be more practical to have certain of the items brought into the classroom.

Of course Chicago's world renowned Merchandise Mart is visited to give the student opportunity to see under one roof a great many of the major furnishings items, such as the hospital bed shown in an accompanying illustration.

Remington Rand's new headquarters and display rooms for office equipment only a few blocks from the Chicago campus were visited, as were also the American Hospital Supply Corporation headquarters, Baxter Laboratories, and the Ethicon Suture plant of Johnson & Johnson. A more or less extra-curricular two-day visit was made by some 25 of the students in February to the Eli Lilly & Company plant in Indianapolis, Indiana.



A class in hospital administration . . Students in the Northwestern University course in hospital administration listen to a lecture on x-ray department layout planning by Mrs. Ernestine Bjork of the Chicago x-ray layout staff of the General Electric x-ray department

Two extra sessions were held in the major equipment part of the course to enable experts from the General Electric X-ray Corporation to explain in considerable detail the theory behind diagnostic and therapeutic x-ray equipment.

Cooperation by manufacturers and dealers . . in conducting this course has made possible its highly practical quality. Most of the instructors are members of these organizations, thoroughly familiar with the products which they describe. The resources of a large manufacturing and merchandising center have been invaluable in providing not only display material but also teaching personnel.

This course also gives the future administrator needed knowledge of the firms with which he will have dealings in the future, and an appreciation of their influence, as producers of constantly improved equipment and supplies, upon better service to the hospital patient. Whether it be janitor supplies, office furniture, rubber goods, plastics, or resuscitation equipment, its design and quality in varying degrees affect the patient's welfare.

Study of the actual items which are bought to build, to furnish, to equip, and to operate hospitals is supplemented in both parts of the course by study of purchasing techniques and organization of the purchasing department.

The course in Planning & Construction and Purchasing & Equipment has full graduate standing at Northwestern University, is required for the Master's degree in Hospital Administration, and carries four semester-hours' credit. It began when Marguerite Ducker, formerly assistant director of the program, aroused the interest of Carl Erikson, of Schmidt, Garden & Erikson, Chicago architects, in planning the design and construction part of the course, and of Roy Johnson, contract sales director of American Hospital Supply Corporation, in coordinating the second part. Raymond W. Garbe of Mr. Erikson's firm is coordinator of the planning and construction series, and Dr. E. T. Thompson of the U.S. Public Health Service gives the two opening lectures on planning.

Dr. Malcolm T. MacEachern, director of the program, has been the consultant and guiding genius of the entire effort, which has been directed toward meeting the need, expressed by former graduates, for concrete knowledge of the what, where, when, how and why of buying before the administrator and the order book first meet. ■

How to secure building materials and supplies

An authoritative source details information on priorities, materials, regulations and methods of coping with them

by **Charles G. Lavin** • Assistant Chief • Division of Civilian Health Requirements

■ YOUR CONCERN today is with the problem of how to provide better patient care and how controls, priorities, and allocations will affect your daily operations. No doubt you would like to know how you can expand your medical services by building additions to existing facilities or by constructing new hospitals and health centers under present day emergency conditions; and how you can continue operating existing hospitals at their present levels, still retaining present standards of medical care.

I will try to give you, to the best of my ability, answers to these two questions. The Defense Production Administration advises us that economic controls will be tighter in 1952 than in 1951. However, the eventual extent or severity of the additional controls which may yet become necessary cannot be predicted, for our future hinges upon a complex and fluid world situation. I can assure you, however, that in the planning and execution phases of the defense mobilization program our civilian health needs are not being neglected even though the primary object of defense mobilization is to give the military what it needs.

Impact of CMP . . Today the nation stands at the threshold of a real turning point in the defense mobilization program. In reviewing defense progress, Defense Production Administrator Manly Fleischmann, said, "We are today at approximately the half-way mark; we can expect that by the summer of 1953 . . three years after the invasion of South Korea . . we shall have achieved the buildup of military strength in being, plus the additional productive capacity to support an all-out mobilization, with which the nation hopes to insure our ultimate goal of national security."

During 1951 civilian industry produced consumer durable goods at relatively high levels because of high raw material inventories. Also 1951's high production, coupled with unexpectedly low consumer demand, kept retailers' shelves well stocked.

In 1952, with nationwide employment at record levels, a return to normal consumer demand is anticipated, and concurrently, a slow but certain depletion of many consumer durable goods, largely because production of military goods in 1952 is expected to double the 1951 rate, approaching about $50 billion a year.

At present it is estimated that the first acute shortages in basic materials will be experienced in the second and third quarters of 1952, with a slight easing of the steel and aluminum problem at the year's end. Everything possible will be done to lessen the impact of civilian shortages through conservation and substitution of materials and by rigorous screening of requirements to assure prompt and efficient use of raw materials.

The most difficult production problem, as far as materials are concerned, will be in the copper supply. There is no prospect of a substantial increase in copper for civilian uses in 1952 or in 1953.

Facilities for the production of aluminum are in the process of expansion; however, the available supply is not expected to fully meet all needs during 1952. There is a prospect of an increase for civilian uses in 1953.

An increase in the supply of steel is expected but most of the increased steel tonnage will be allotted to the military program in 1952. Any increase during this period in steel allotments for civilian use will probably be for items fabricated almost entirely from carbon steel or chrome stainless steel. The prospects for next year are, however, brighter.

CMP Regulation 6 and NPA Order M-4A . . One of the first steps taken by the National Production Authority and the Defense Production Administration to conserve materials for the most essential construction was to issue CMP Regulation 6 and a "limitation order" on construction known as NPA Order M-4A.

Order M-4A outlines the "ground rules" for limiting certain types of building construction and limiting the use of building materials in all construction as one means of conserving critical materials for the defense program.

Health facilities need not always apply to the Public Health Service for construction permits. Direction 1 to CMP Regulation 6 provides for self-certification by construction projects wherever delivery requirements do not exceed two tons of carbon steel or two hundred pounds of copper per calendar quarter and where no aluminum, stainless steel, or alloy steel are needed. The allotment symbol U-8 is used in such cases, and the rating symbol for non-controlled equipment and supplies is DO-U-8.

At the present time those health facilities requiring delivery of more than two tons of carbon steel or two hundred pounds of copper and any quantity of aluminum, stainless

Presented at the American Protestant Hospital Association, Cleveland, Ohio, February 22, 1952.

Presidents . . Three leaders of the A.P.H.A. Left to right are president-elect, Lee S. Lanpher, Lutheran Hospital, Cleveland, O.; president, John G. Dudley, Memorial Hospital, Houston, Texas; immediate past president, Leo M. Lyons, St. Luke's Hospital, Chicago, Ill.

steel, or alloy steel in one calendar quarter for construction, must file Form CMP-4C with the Public Health Service. CMP-4C is a three-way application for a permit to construct, otherwise known as an "authorized construction schedule," for an allotment of controlled materials, and for a priority rating to use in purchasing non-controlled materials and equipment.

The Defense Production Administration allocates on a quarterly basis to the Public Health Service quantities of steel, copper and aluminum which, in turn, are allotted by the Division of Civilian Health Requirements to the eligible projects based on essentiality of construction.

Essentiality . . All projects are examined carefully to determine if they are urgent and essential. First, every effort is made by the Public Health Service to support all under way projects, given a construction permit with an initial allocation of controlled materials, through to final completion.

Emergency replacements of partial or complete facilities damaged or destroyed by fire, flood, storm, or which are necessary for the protection and safety of the occupants, are given preference over other repairs, renovations and additions. This replacement type even receives a priority over the building of completely new facilities.

Projects in defense housing areas coming under Public Laws 139 and 96, and in industrial areas, generally are given preference over those in non-defense areas unless there are extenuating circumstances.

Four major factors of essentiality are: the degree of need; the relationship of the project to the defense effort; the type of medical or health service rendered; and the type of the construction (repairs, additions, etc.).

Construction . . We received 247 requests for permits to begin new construction in the *third* quarter of 1951. The 247 requests included new buildings, additions to existing structures, repairs and renovations. Of these we were able to approve 231 during the third quarter. Of the remaining 16 projects, 13 received a fourth quarter, 1951, permit and allocation, and three received a first quarter, 1952, permit and allocation. Thus we have approved by now all requests for new construction received during the third quarter. In this same 1951 period 623 under way projects were given allocations of materials.

Requests for permits and allocations for the *fourth* quarter, 1951, totalled 381. We were able to approve 314 of them during the fourth quarter. Of the remaining 67 projects 54 received first quarter 1952 allocation and 13 were given allocations in the second quarter of 1952. Therefore we have acted on all requests for new construction received during the fourth quarter. During this same period 658 under way projects were given allocations.

We have received to date 276 applications for permits and allocations in the *first* quarter, 1952, and we were able to approve 169 of the most urgent project applications in the first quarter of 1952. The remaining 107 projects have or will be given permits and allocations in the second quarter 1952, thereby completing action on all requests received in the first quarter. Six hundred and ninety-nine projects were given allocations in this same period.

We anticipate receiving approximately 250 applications for new construction projects which propose to start in the *second* quarter 1952. We estimate that we will be able to approve, within availability of materials, about 175 of them. Seventy-five of the less urgent will probably be deferred until the third quarter. Five hundred and thirty-three under way projects were given second quarter 1952 allocations.

Although we have not yet completed a full year's operation under CMP, we estimate that on or about June 30 of this year approximately 1,200 requests for new starts will have been received since the start of CMP. Seventy-seven per cent will have been approved in the quarter in which the permit and allocation was requested. Of the remaining 23 per cent, approximately 21 per cent will have been deferred one quarter but less than 2 per cent will have been deferred two quarters. We are hopeful that the total number of deferrals in the latter half of this year will level off and possibly be less than the average number to date.

Although we probably will not receive the full amounts of controlled materials necessary to support the total health facility construction program at its normal operating level if conservation practices are followed to the maximum we hope to be able to continue to approve the vast majority in accordance with the requested construction schedules. There will continue to be some deferrals but if everybody does his utmost to conserve materials the number of such deferrals should decrease.

Conservation . . Engineers and architects can help their clients by designing structures requiring a minimum of critical materials.

Copper brass mill products, structural steel shapes and steel plates are the controlled materials which we believe will be in short supply in the next 10 to 18 months. The resourceful architect who can eliminate these items in his design, or cut them to the minimum, renders an invaluable service to both his client and to the nation. The use of

excessive quantities of scarce materials, especially copper, can only result in delaying your construction project.

The vital importance of the "materials conservation program" was stressed by Defense Mobilizer Charles E. Wilson in a letter to DPA endorsing the program. He wrote that "The success or failure of efforts to promote conservation could mean the difference in some areas between success or failure in military production and in others between maintaining a satisfactory volume of consumer goods production.

"I hope," he added, "that the Defense Production Administration will continue to push the work on conservation in construction and that you can expand the work in other areas in vigorous fashion. This is a matter about which I feel strongly and an operation which I believe will be vigorously supported by both industry and labor."

Together DPA and NPA have recommended specific design practices for the conservation of critical materials.

Typical of these practices are:

1. The use of wall-bearing masonry construction in lieu of structural steel frame or reinforced concrete frame where possible.

2. The substitution of reinforced concrete for structural steel.

3. The substitution of non-critical fire-proofing substances for critical ones.

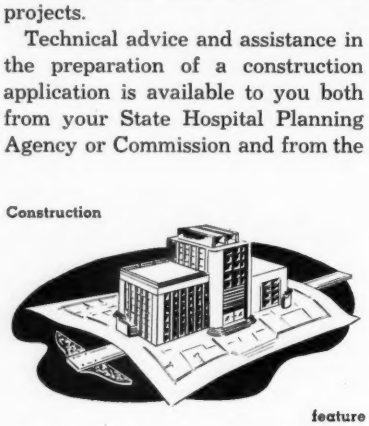
4. The use of light-weight concrete and plaster aggregates to replace heavier aggregates in order to decrease the quantities of structural or reinforcing steel needed for load carrying members and foundations.

5. Where conditions permit the substitution of galvanized steel or wrought iron pipe in lieu of copper tubing and the use of substitutes for copper flashing. Copper brass mill products are in extremely short supply.

State agencies . . We ask that all applications for new hospital construction be submitted to the Public Health Service through the State Hospital Planning Agency. We have such an arrangement with the State Agencies because they usually are consulted early in the planning stages and they are familiar with the medical care needs in the various states. We have found their advice and assistance helpful in determining the essentiality of the projects.

Technical advice and assistance in the preparation of a construction application is available to you both from your State Hospital Planning Agency or Commission and from the

Construction



feature

regional offices of the Federal Security Agency. I urge that you take advantage of these services for they are organized to assist you in processing and expediting approval of your application.

Application for health facility construction should be made on Form CMP-4C following the provisions of the CMP Regulation on Construction (CMP Reg. 6), and the special instructions in Special Information Sheet No. 8 issued by the Public Health Service. The application should be forwarded in an original and three copies to the State Hospital Planning Agency or Commission in your state, together with supporting data of essentiality and need. The State Hospital Planning Agency or Commission will review your application and make recommendations to us through the Regional Medical Director in the FSA Regional Office.

Assistance in placing ACM orders and rescheduling . . Allotments of controlled materials are issued by the Public Health Service on Form CMP-13 . . phased by calendar quarters. A procedure to assist persons in placing authorized controlled materials orders with producers of steel, copper or aluminum has recently been issued by the National Production Authority.

The NPA Metals and Minerals Bureau will now help to see that allotments under the Controlled Materials Plan find a place as firm orders on producers' mill schedules.

Before applying to NPA for assistance in placing authorized controlled materials orders, holders of CMP allotments should first make every effort to place the orders themselves. Assistance cannot be given until the holder of the CMP allotment is prepared to show that he has tried to place his order with several suppliers and has been unable to do so.

Application for assistance should be made on NPA Form 148, giving information needed by the responsible NPA officials to identify the particular tonnage involved. Copies of the form may be obtained from Department of Commerce field offices; NPA industry divisions; the Steel, Copper, and Aluminum and Magnesium Divisions of NPA; the Office of Small Business of NPA; State Hospital Planning Agencies; State Health Department and FSA Regional Offices.

When filing Forms NPA-148 care should be taken to make them complete. Space is available on the form for name and address of the applicant, allotment symbol, allotment record, previous purchase record, applicant's experience in attempting to place orders and other pertinent data.

We believe that most of the orders can be placed if this system is followed. If the NPA is unable to help in placing such orders, the Division of Civilian Health Requirements, Public Health Service, should be notified, giving full details. This division will then contact NPA in behalf of such holders.

If orders cannot be placed, accepted and scheduled by suppliers for delivery in the quarters in which allotments are valid because (1) suppliers are unable to schedule delivery, or (2) construction has been postponed and the orders have not been scheduled; the unused portions of allotments should be promptly returned on Form CMP-12 and a revised Form CMP-4C should be submitted for approval of a new construction schedule and allotments in subsequent quarters.

In case allotments in excess of actual needs were made, and no further allotments are needed, only the Form CMP-12 need be submitted. It is especially important

that unused allotments be returned promptly in order that allotments can be made to other projects.

If orders have been placed with, accepted and scheduled by a supplier for delivery in the quarter in which the allotments are valid and you experience a delay in construction and do not need the materials until a later period or if the supplier cannot effect delivery as scheduled, deliveries may be rescheduled by the person placing the order, or by the supplier. In such instances the orders are still chargeable to the quarter in which the allotments were originally valid even though delivery is made in a subsequent quarter.

Medical supplies and equipment . . You are all interested in knowing, I am sure, something about the present picture with respect to medical supplies and equipment which are so vital to the maintenance and operation of existing health facilities.

Naturally if not enough sterilizers, forceps, sutures, bandages, x-ray equipment and other vital supplies and equipment are produced you will be among the first to feel the pinch. Certainly one of our principal interests is to see that a continuing and adequate supply of such items is produced.

In addition to plant expansion in the field of antibiotics, we have recently been able to assist in the expansion of plant facilities in the manufacture of gauze, bandages, burn dressings, ACTH, cortisone, plastic bottle closures, hypodermic needles, syringes, elastic bandages, blood plasma and the blood extenders.

Since there is essentially no stockpile of medical supplies and equipment all claimant agencies interested in the distribution of these items have recommended to the control authorities that their output not be hampered by cut-back orders limiting the manufacturer's supply of basic materials. In several categories of medical supplies and equipment there are only a few producers and their entire production capacity is needed. As the claimant agency for the civilian population in the health field we have emphasized, first, the essentiality of hospitals and other health facilities; second, the importance of health and medical supplies which are so necessary to maintain the health and welfare of both the military forces and the supporting civilian population; and third, the necessity for the continued production of equipment of high quality. We have urged against the forced substitution of inferior materials in functional parts.

Orders for hospital beds currently require approximately 12 months for delivery while sterilizers require about nine months before delivery can be made. For this reason we urge you to place your orders for medical equipment as early as possible because you may experience a longer waiting period for delivery in 1952 and 1953 due to the increased needs of the Department of Defense. This does not mean stockpiling but advance orders should be timed to meet construction schedules and replacement needs.

The materials allocation assigned by the DPA to the Scientific and Technical Equipment Division of NPA has averaged higher than in any other industry division. This division has the responsibility of redistributing controlled materials to manufacturers of technical lines, including medical supplies and equipment. As you know, up to the present time shortages in this area have been held to a minimum but the situation may be changed when military and civil defense requirements become greater. We can assure you that we will continue working to solve this serious problem.

CMP Regulation 5 . . I would like to call to your attention the recent changes in CMP Regulation 5 which provides for self-assignment of DO ratings to orders for both controlled and non-controlled materials and products necessary for maintenance, repair and operating supplies, minor capital additions and minor installations.

Health facilities may now self-assign the allotment symbol MRO and rating DO-MRO to obtain: MRO supplies based upon a quarterly MRO quota; minor "capital additions" costing less than $1,000 for any one addition; and minor "installations" costing less than $1,000.

Health facilities, however, may not apply or extend the allotment symbol MRO or the rating DO-MRO to obtain certain items. These are listed in CMP Regulation 5.

Existing health facilities should apply directly to the Regional Medical Director of the Public Health Service for priority assistance when the provisions of CMP Regulation 5 are not applicable. In such instances a DO-Z-1 rating is issued.

Closing remarks . . The three-point DPA program for defense mobilization on which we are embarked provides for first, military preparedness; second, industrial expansion and third, maintenance of a civilian economy at as high a level as materials permit and designed to prevent as much unemployment as possible.

It is a realistic, tough program but if you are willing to accept the idea that the nation is in real danger I think you will agree that it is necessary.

CMP rests on a sound economic theory that was tried and tested in World War II. It is encouraging that the military and Atomic Energy Commission requirements for controlled materials are increasing. This sign points to a tremendous volume of defense production that is now building up. In due course, the bottlenecks will disappear, the dam will burst, and I predict that you will see by 1953 and 1954 a production comparable to that which amazed the world in 1943 and 1944 . . it will be smaller in volume but equal in intensity.

In comparing allocations made to other segments of the civilian economy . . including the amounts granted by DPA for the construction of schools and libraries, water and sewerage projects, roads and streets, office buildings, homes and apartments . . we feel that the allocations made by DPA for health facility construction, while not fully adequate, have been equitable, taking into consideration, of course, the fact that the requirements of the various claimant agencies, including the military and the Atomic Energy Commission, exceeded the supply by approximately 150 per cent. ■

Dr. MacEachern tells APHA he hopes for improvements in standards

■ MALCOLM T. MAC EACHERN, M.D., who knows more than any other single person about hospital standards, told the American Protestant Hospital Association at Cleveland Feb. 21 that "I do not believe there will be many changes in present requirements [for hospital standards] for the time being at least. However, one might well expect improvement in the present standards and an extension to other services not yet covered. I would also prophesy that this program of accreditation of hospitals will spread its influence throughout the world."

In expanding on his subject of standards and professional relationships Dr. MacEachern observed that "We have been blessed in this country by voluntary high standards of care for our sick people and through the hospital standardization movement these permeated every hospital and have done a great deal to save human lives and to prevent chronic invalidism. In addition they have done a great deal to reduce the period of illness, to bring the head of the family safely through his trying illness, to get the worker back to production and many other benefits to humanity.

"The standardization program required each segment of the hospital to deliver safe and efficient service for the patient regardless of the task to be performed. This meant full compliance with the standards set and promulgated by the American College of Surgeons for the past 34 years, which is soon to be taken over by the Commission on Accreditation.

"As you know, this commission will be constituted of five powerful organizations . . the American Medical Association, the American College of Surgeons, the American College of Physicians, the Canadian Medical Association and the American Hospital Association.

"This means the united forces of medicine and hospitals of two great nations will now establish and administer the standards for hospitals. These standards will be mandatory in order to meet approval of the commission. No greater force in the world ever existed for the betterment of hospitals. There is no doubt that the influence of the Commission on Accreditation will in due course make it difficult for a hospital to continue if it fails to meet the requirements. . ."

Dr. MacEachern pointed out that "We are a great people for standards and that is why we have made unparalleled progress in education, in industry and in health. We have advanced under the guidance of well thought out and intelligently applied standards which serve as guiding principles of performance and which are adjustable and flexible. It is standardization in a flexible manner to best fit the situation and obtain the best results.

"In the care of the sick and injured in the hospital we have arrived at a sound, basic knowledge of how all departments and services must be carried on and coordinated to produce the desired results. Already standards have been worked out, not only for the hospital as a whole but also for each department or service individually.

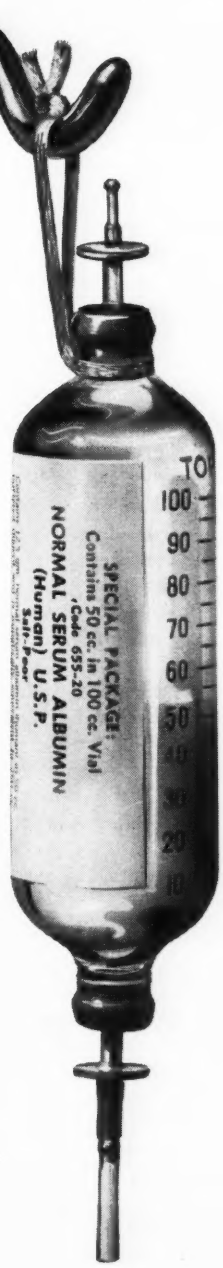
"Generally speaking, these standards embrace certain fundamentals or basic considerations involving

Officers* . . elected Feb. 22, 1952 at Cleveland, O., to serve the American Protestant Hospital Association for the coming year

* These officers are, seated, left to right, president-elect, Lee S. Lanpher, administrator, Lutheran Hospital, Cleveland, O.; president, John G. Dudley, administrator, Memorial Hospital, Houston, Texas; treasurer (re-elected) L. B. Benson, D.D., administrator, Bethesda, Hospital, St. Paul, Minn.; standing, left to right, first vice president, C. E. Copeland, administrator, Missouri Baptist Hospital, St. Louis, Mo.; second vice president, Lt. Colonel Florence Turkington, Salvation Army, New York, N.Y.; president, Association of Protestant Hospital Chaplains, Chaplain Carl J. Scherzer, Protestant Deaconess Hospital, Evansville, Ind.

NEW shock therapy kit

Cutter 50 cc. Albumin... Osmotically Equivalent to 250 cc. of Plasma



RAPID RESPONSE. Each double-ended bottle contains 12.5 gm. of albumin in 50 cc. of buffered solution which is osmotically equivalent to 250 cc. of citrated plasma. This draws approximately 175 cc. of additional fluid into the circulation within *15 minutes,* when injected intravenously in a well-hydrated patient.

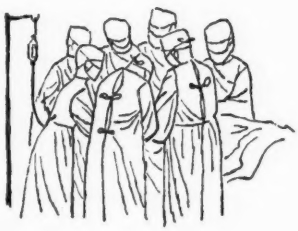
FAST ADMINISTRATION. The new space-saving Cutter 50 cc. Albumin Shock Therapy Kit features a sterile, ready-to-use administration set . . . immediately sets-up on the spot—anywhere, any time. With only one fifth the fluid volume of plasma, administration time can be reduced.

HEAT TREATED AGAINST HEPATITIS VIRUS.

Human Serum Albumin's stability permits pasteurization in the vial for 10 hours at 60° C. as a precaution against homologous serum jaundice virus.

Albumin In Other Conditions

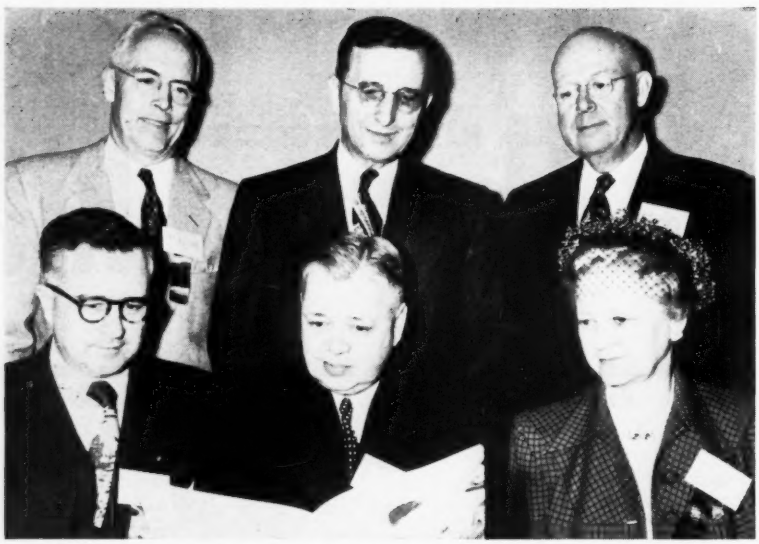
Write for a booklet describing the use of Albumin in hypoproteinemia, renal diseases, cirrhosis. Cutter Laboratories, Berkeley, California.



Stock **CUTTER**

ALBUMIN SHOCK KITS

(Normal Human Serum Albumin-Salt-Poor)



Methodist leaders** . . Officers of the National Association of Methodist Hospitals and Homes elected Feb. 21, 1952 at the organization's annual convention in Cleveland, O.

such elements as physical requirements, organization, administration, personnel, records and conference. These are standards of procedure and performance. Every single activity in the hospital can be molded accordingly and the highest level of efficiency assured. . ."

Hospital councils . . A hospital council can stimulate better cooperation, understanding and common benefits without interfering with the day to day operation of individual hospitals, the APHA was told by Guy J. Clark, executive secretary of the Cleveland Hospital Council.

Among legitimate activities of a council listed by Mr. Clark are development of:

1. Good, sound accounting practices.

2. Proper reimbursement from governmental agencies for services for which they may be responsible by law.

3. Sound business practices, fair employment conditions, agreement on a schedule of salaries and wages for positions of like nature.

4. Follow up local and state legislation affecting hospitals.

5. Cooperate in hospital educational activities.

6. Set up standards of surgical and medical care.

7. Plan community hospital programs to avoid duplication of service.

Mr. Clark described how a Hospital Finance Corporation was set up in depression days to enable patients to pay their hospital bills without being charged exorbitant interest.

Good patient care . . The place of the administrator in good patient care in a church hospital was outlined in a panel discussion by E. I. Erickson, administrator of Augustana Hospital, Chicago, and president of the American College of Hospital Administrators.

". . . The administrator must know the requirements of good hospital care and so lead and inspire his associates and employes that the results will satisfy the public, the medical staff and the board of trustees.

"This requires knowledge, experience and hard work. If these are applied in accordance with the ideals set forth in the parable of the Good Samaritan and other teachings of Holy Writ, the results will not be perfect patient care in every instance but certainly a high level of achievement."

The doctor . . The doctor's place in good patient care in a church hospital involves ". . . complete cooperation between the professional and the administrative staffs if we are to reduce the cost of medical care," said Dr. J. H. Lazzari, chief of surgery, Lutheran Hospital, Cleveland. "We are all equally interested in providing the maximum of medical service for the minimum cost to the consumer. . ."

The chaplain . . ". . . To promote a religious spirit in a large institution is not an easy task. Certainly a chaplain cannot even begin to do it by himself," said Carl J. Scherzer, D.D., chaplain, Protestant Deaconness Hospital, Evansville, Ind., in considering the chaplain's part in good patient service in the church hospital.

"It requires the cooperation of the administrator first of all, then the nursing authorities as well as the medical and surgical staff. When this cooperation is not forthcoming the religious program is limited to the personal contact of the chaplain with the patients and certain individuals of the personnel. . ."

Blue Cross . . L. B. Benson, D.D., administrator of Bethesda Hospital, St. Paul, Minn., observed that ". . . Blue Cross is effective in American hospitals because Blue Cross is operated on a non-profit basis. During the 12 months of operation last year in Minnesota over 90% of the money received by Blue Cross has been returned to the subscriber and we have been able to keep our operating expense around 8.3%. I don't know of any other organization that can give so much to the subscribers or to the public for what they pay for their contracts.

"As one of the early organizers of Blue Cross in Minnesota I don't know of any other type of Plan that could have been more helpful to our Protestant institutions, particularly in this day and age when it is not expected that employes of a Protes-

continued on page 90

** Seated, left to right, are: president-elect for 1953, Rev. Harold R. Barnes, executive director, Finch Children's Home, Oakland, Calif.; president for 1952, Rev. B. W. Selin, superintendent of Bethany Home and Hospital, Chicago; secretary, Miss A. M. Jacobson, administrator, Bellin Memorial Hospital, Green Bay, Wis. Standing, left to right, retiring president, Neal D. Ireland, superintendent, Pacific Home, Los Angeles; executive secretary, Dr. Karl P. Meister, Methodist Board of Hospitals and Homes, Chicago, Ill.; vice president, Dr. W. C. Perdew, administrator, Bronson Hospital, Kalamazoo, Mich. The treasurer, A. C. Durden, Macon, Ga., was unable to attend. This is a Methodist Information photo.

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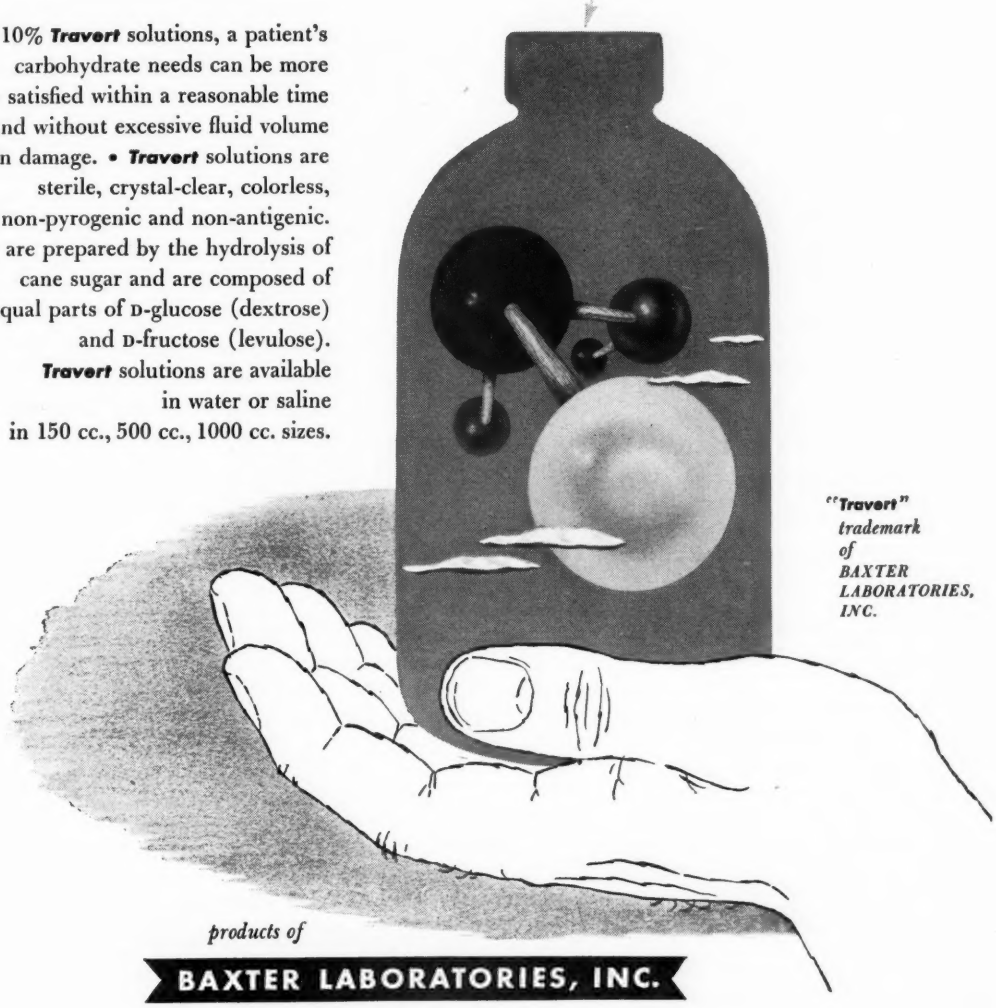

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AMERICAN HOSPITAL SUPPLY CORPORATION

GENERAL OFFICES • EVANSTON, ILLINOIS

Citizens build own hospital . . . . in Ennis, Montana

continued from page 4

Steve Hubner and Billy Sprout . . often didn't survive, for there was no doctor in all of long Madison Valley, nor was there a nurse.

It had been like that almost from the time the hardy pioneers settled in the valley in 1864, Ennis people say. "Those sturdy, fearless men and women who trekked west were used to hardships . . the weak didn't pioneer . . and they were seldom sick, but when they were, they often died."

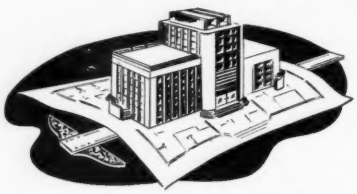
Years later doctors apparently still found life in this wild, unsettled country a hazardous experience, judging from the unsteady succession which came and left. Some stayed on for a time because they loved the free and rugged Western life; others moved to communities more prosperous and hustling where hospitals and clinics encouraged the practice of good medicine. "Old Doctor Smith froze to death on Virginia City hill in the blizzard of '82," one resident remembers, "before anyone could get through to help."

It took another blizzard . . the one in 1948 . . to convince Ennis that things hadn't improved much. For ten days the road to Norris, the nearest town, was lost beneath the drifts and no mail got through for eight more days. They still had no doctor, and when a young girl convulsed with glandular fever, a doctor had to be begged to fly in.

Not interested . . After the crisis passed, it was evident that Madison Valley had had enough of the old ways. "Doctors nowadays just aren't interested in horse-and-buggy practices," parents said, "but *something* has got to be done to protect the lives of our children."

Most Ennis people regard as a red-letter day the day Ray Kohls spoke up at a meeting of the Commercial Club. "We've all seen some mighty sick people, often in our own families, who couldn't stand the trip to Butte or Bozeman," he said. "Lots of times it's just a matter of life or death. I suggest we start *right now* to raise money for a doctor's home and office." Fellow businessmen argued that a doctor wants more than office space ("He has to have a place to put his patients") . . they'd have to build a hospital. The approval was thundering.

That was the beginning of a project, titanic in size for a scattered Western community, which no one in Madison Valley will ever forget. When a meeting was called to form the Madison Valley Hospital Association, hundreds of resolute people . . it seemed like the whole valley . . flocked in to have their say. For hours they attacked the problem of medical protection for their people with the keen dogged tenacity of their pioneer forefathers . . and no one wanted to turn back. "It was the only thing to do," a board member says. "We could have waited the rest of our lives for a right time to begin."



For the people . . From the first, Madison Valley seemed determined to manage its own hospital in its own way. Had not these been an exacting, persistent people, concerned with every minute detail, it is doubtful that the hospital would ever have been completed . . for gigantic obstacles lay ahead.

When the only hospital plans available from the State Board of Health specified a $150,000 building . . an unthinkable sum! . . they spent a year painstakingly studying their needs, then hired an architect to draw up special plans for a five-bed hospital to cost $25,000.

When they ran out of funds with only the frame, roof and chimney job up, they carried on the work themselves. Men laid linoleum, painted, carpentered. Women varnished floors, put the first coat of paint on the woodwork and served sandwiches and coffee to workers.

When they applied for a hospital license and were told it wouldn't be granted without separate delivery, operating and emergency rooms, all with identical facilities, they whittled the State Board of Health down by compromise after compromise. Finally they got their license by installing a delivery room, bedpan-washing facilities, nurses' station and sterilizing room.

Meet the deficit . . They added up the final figures and discovered that the hospital had cost $37,000 . . $10,000 more than they had raised. Women organized food sales, card parties and box socials. The Ennis Roping Club staged a rodeo. Collections were taken up at nearby ranches. And those who gave once gave twice and then gave again.

As the volunteers were brushing the final coat of paint on the corridor walls, the first sign of encouragement arrived. Young Dr. Ronald Losee came to settle with his wife in the little Western community and to be resident physician at the new hospital. With him, Doctor Losee brought x-ray apparatus, operating instruments, a basal metabolor, laboratory equipment and an electrocardiograph . . the hospital's first equipment.

Formal opening was now but a month off and the whole valley teemed with excitement. At Bear Creek, the women of the Episcopal Church were stitching up operating gowns. In Ennis and on the ranches, people were collecting beds, sheets, towels, pots and pans. But like the persistent people who created it, their hospital didn't wait. A month ahead of schedule, it swung open its unpainted doors and nearly completed facilities to care for two young people who had been thrown through a glass window in a motorcycle accident.

Today . . as you walk through the fine little hospital, situated on two acres of land just outside of Ennis, you are constantly reminded of the generosity of the local people. The operating table is the gift of the Trinity Guild at Jefferson. Stevie Hubner rests in a single room furnished by one individual and pro-

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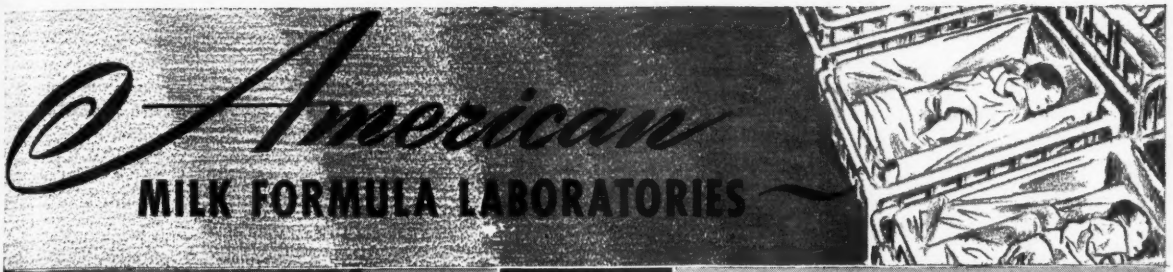
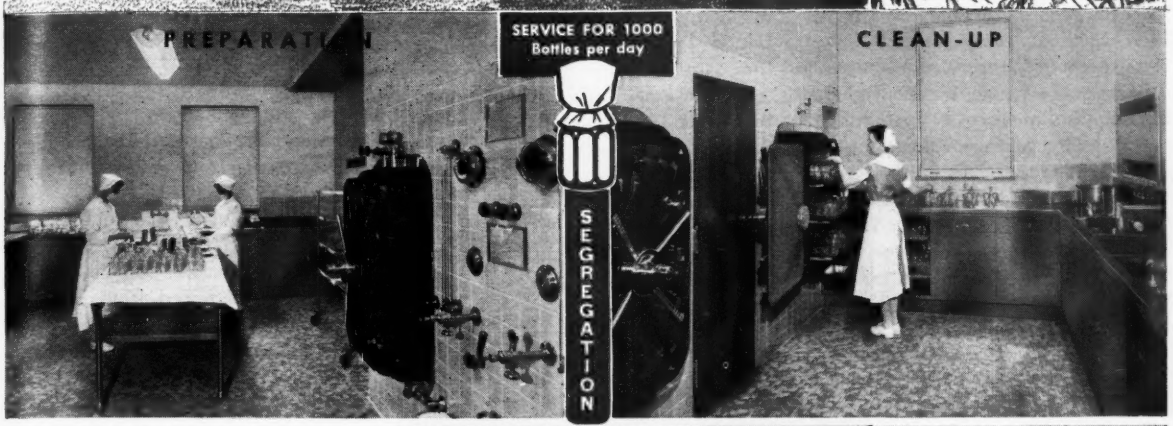




Courtesy Elizabeth Steel Magee Hospital

THE *Large* HOSPITAL

requires unusual facilities and special refinements to efficiently produce safe formulas for a large number of infants.

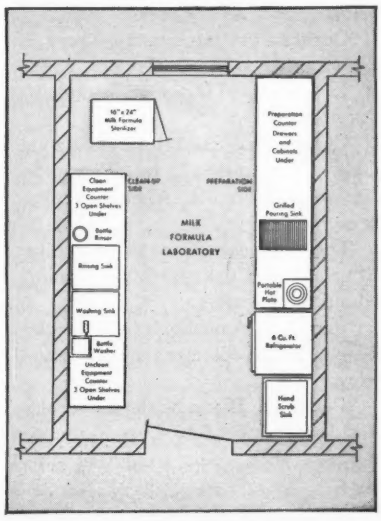
Courtesy Shadyside Hospital

THE *Average* HOSPITAL

must have adequate space for segregation of "clean-up" and "preparation" areas. Operating efficiency and safety are dependent upon proper arrangement of counters, cabinets, sinks and essential sterilizing equipment.

THE *Very Small* HOSPITAL

is frequently unable to allocate sufficient space for the preferred two-room (segregated) plan. This plan is typical of a small formula room designed to operate with efficiency and safety under competent supervision.



***Consult** American Sterilizer Company's Milk Formula Planning Department. May we send an experienced engineer, or give you preliminary data by mail? Write Department HC-3.*

AMERICAN STERILIZER COMPANY

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vided with an annual $50 maintenance fund. The Ennis Woman's Club furnished the two-bed maternity room. Another bed was donated by the Lions Club of Ennis.

"Since September, 1950, 241 patients have used these facilities," Doctor Losee reports from behind a stack of records. "Forty-two have been accident cases and 25 have been mothers giving birth to a new generation of hardy Western stock. Though we average 17 patients a month, they all seem to come at once."

In the immaculate delivery room, Stella Maddox has just given birth . . safely . . to a baby daughter, born a month premature. Her rancher husband sped her to the hospital merely a few hours ago. Gretchen Sprout, president of the volunteers, is carrying a luncheon tray to the corner room and another familiar figure approaches with scrub pail and mop. You don't need to be told that she is a volunteer, too, for though their hospital is long since finished, Ennis people have continued to supply the lifeblood of their little institution. They wax, scrub, clean, bathe patients and bring food trays, earning a free day of hospital care for themselves or their families with each 50 hours.

No work is too hard, they tell you, if it brings a better life for all. And that is what the people of Madison Valley have brought themselves. ■

More films for hospitals

■ HOSPITALS have made great use of the list of films printed on page 35 of the December 1951 HOSPITAL MANAGEMENT for showing to various hospital groups, judging from inquiries.

By writing to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y., or by contacting a Squibb representative, the following 16 mm. selections from the company's film library are available without cost:

Anesthesia

"Curare," by John B. Dillon, M.D., color, sound, 25 minutes.

"Curare in Barbiturate-Oxygen Anesthesia," by T. C. Davison, M.D., A. H. Letton, M.D., color, sound, 20 minutes.

"Curare in Barbiturate-Nitrous Oxide Anesthesia," by Fernando Hudon, M.D., color, silent, 20 minutes.

"Endotracheal Anesthesia," by Charles McCuskey, M.D., color, sound, 20 minutes.

"Pediatric Anesthesia," by Digby Leigh, M.D., color, silent, 30 minutes.

"Pudendal Block with Demerol® and Intracaine®," by Lees M. Schadel, Jr., M.D., color, sound, 10 minutes.

Antibiotics

"Principles of Penicillin Therapy," color, sound, 20 minutes.

"Streptomycin Drugs in the Treatment of Tuberculosis," by H. Corwin Hinshaw, M.D., color, sound, 30 minutes.

Nutrition

"Malnutrition in the Hospital Patient," by Eugene F. DuBois, M.D., Robert Elman, M.D., Herbert Pollack, M.D., color, sound, 30 minutes.

"Modern Nutrition," by Norman Jolliffe, M.D., Tom D. Spies, M.D., W. H. Sebrell, M.D., Robert Goodhart, M.D., color, sound, 45 minutes.

"Nutritional Aspects of Tropical Disease," color, sound, 30 minutes.

Poliomyelitis

"Curare in Acute Anterior Poliomyelitis," by Nicholas S. Ransohoff, M.D., color, sound, 45 minutes.

Cardiology

"Pronestyl Hydrochloride — A New Drug for the Treatment of Ventricular Arrhythmias," color, sound, 5 minutes.

"Coarctation of the Aorta," John C. Jones, M.D., color, sound, 25 minutes.

Rheumatic Diseases

"Tolserol in Rheumatic Diseases," by Richard T. Smith, M.D., color, sound, 20 minutes.

Problems

continued from page 41

trols, which change with the wind, labor shortages, price increases, substitute materials, inconsistent workmanship . . these and many more unpredictables confront the new hospital almost daily.

Yet with proper foresight and planning many of these obstacles can be overcome. Close supervision on the job will detect and prevent sub-standard materials and faulty workmanship from going into the building.

When the Marin General Hospital was faced with material and equipment shortages, we built our own warehouse, advanced funds to the contractor, and insisted that he procure all available material that would be needed during the course of construction. Ninety-five per cent of our equipment needs were met before the foundations were complete, and that equipment safely stored away against opening day. Such procurement before price increases went into effect has already saved us literally thousands of dollars. The warehouse will eventually become a combination maintenance shop and bulk storage facility.

Realistically looked at, the problems of planning, building and equipping a new institution, as rugged as they appear today, show no promise of anything but an increase in severity for the future. Costs will continue to rise; materials will continue to be scarce and will become scarcer; labor shortages will become more acute; fund raising campaigns will meet with greater resistance.

Nothing is to be gained by delaying proposed construction or the procurement of needed equipment. The time to build and buy is NOW!

Indiana psychiatric hospital changes its name

■ NORWAYS FOUNDATION HOSPITAL is the new name for Norways Sanatorium, 1800 East Tenth Street, Indianapolis, Ind., sponsored by Norways Foundation, Rodney W. Hemsworth, administrator, announced.

Norways Foundation Hospital is the oldest private psychiatric hospital in Indiana, established in 1898, as Sterne Memorial Hospital.

news of voluntary health plans

Third party payer in future financing of hospital care

by **Harry Becker** Associate Director • Commission on Financing of Hospital Care

■ OF THE MANY THINGS that make America great . . which set us apart from most other countries of the world . . one is our never ending struggle to achieve a democratic society. Our greatness is not in the solutions we have found, but rather in our common desire to achieve the unrealized possibilities of our democracy. From this source, this philosophy, flows our vision, our determination to meet challenge. Within the stream of this philosophy we develop our concept of an expanding and dynamic society.

For the hospital administrator and the members of his board of trustees this expanding and dynamic society has created and will continue to create many new, often difficult problems. During the past decade the impact of our changing social and economic life has been felt more by the hospital than most other institutions. There are many reasons why this is true. The pressures for more services and for higher standards of care have been intensified at the same time that costs have more than doubled.

The problem . . There is no mystery about the concern over the increasing cost of hospital care so often expressed by the patient, the attending physician, the hospital, and the third party payer. It is not possible to expand standards of care, provide services to more people and still meet higher costs of operation without, at the same time, asking the consumer of hospital services for more money. The financial problem that confronts hospital administrators is, in large part, the direct result of a lag between the upward movement in costs of providing services and the willingness and ability of the buyer of services to pay the bill.

Hospital care, unlike other elements of our standard of living, is something we cannot go without even if our understanding and acceptance of the cost of care lags behind the upward cost of providing necessary hospital services. This is well illustrated by the fact that hospitals continue to provide care for recipients of public assistance even though state legislatures are unwilling to increase the allocation of tax money in direct relation to the rising cost of providing care. It is also shown in the public's reluctance to pay increased rates for prepaid hospitalization protection even though cost of living figures alone show the reason for higher premiums.

We should not be too surprised or disturbed because the increase in cost of providing hospital care has created problems for us. What should concern us and give us cause for thoughtful and determined action is how we are going to meet the problems which have arisen. And, as we plan to meet our present day problems of financing of hospital care, we must at the same time give attention to those problems which will emerge in the near future.

Slower cost increase . . Briefly, we can probably expect in the period immediately ahead a continued rise in hospital operating costs. Although in the past decade costs have risen at the rate of about 13 to 15 per cent a year . . more than one per cent a month . . the rise in the next decade may be expected to be at a somewhat slower pace. It is also reasonable to assume an expanding consumer demand for hospital services and a broadened scope and supply of services. As a result the percentage increase in cost of prepaid hospital care, per thousand persons covered by a prepayment plan, may very possibly exceed the percentage increase in the daily cost of hospital operation. In other words, the relative rate of increase in monthly cost of prepaid hospital care to the public might exceed the rate of increase in daily cost of operating the hospital.

Patient increase . . Another factor to consider as we develop plans to meet the problem of financing the cost of hospital care is the probability that the number of people per thousand population who will use hospital facilities will tend to increase in the future rather than decrease. This will occur at the same time hospital services are expanded to make more generally available such items as diagnostic and rehabilitation services. Also, the upward trend in our general educational level, the improved income status of the people, and the steady increase in the proportion of persons in the older age groups will be factors which tend toward more use of hospital services. We can probably expect, especially as the national defense expenditures reach a plateau, an increase in the total supply of hospital beds.

More funds, substantially more, will be needed for investment in facilities and equipment in the next

A paper read Feb. 14, 1952 before the Wisconsin Hospital Association at Milwaukee, Wis.

ten years than were allocated for these purposes during the past decade. Likewise, the number of persons trained in the health professions will increase, and the amount of funds required for training programs will gradually, but surely, move upward.

It is not possible to evaluate fully the effect of new medical knowledge on use of hospital facilities and services, but in all probability the developments in medical science will mean increasing use of the hospital as a principal community agency where medical care is made available.

To some extent the pressures for greater utilization of hospital facilities may be offset by an increase in preventive care and improved productivity in hospital operation. But the effect of these compensating factors will, in the over-all, be relatively unimportant as major factors in reducing costs to the third party agency. In fact, it might be argued that they may, in the short term, tend to increase costs.

Third party payments increasing . . In our general consideration of economic problems confronting the hospital administrator we must not overlook the shift in source of hospital income. The per cent of hospital income from endowments and charity sources is tending downward. This trend will probably not be reversed. The proportion of hospital income obtained directly from the patient at the time of hospitalization is growing less each year. At the time that these sources of hospital income have been reduced, the significance of the "third party" payer has increased and will continue to increase.

The primary source of hospital income in the future will be payments made by third parties. Persons actively employed are generally coming to appreciate that hospital care is an item of family expense that can best be met only through regular monthly prepayment. Today, approximately 75 million persons, or about one-half the total population, have some form of prepaid hospital protection. In the past ten years the number of persons participating in Blue Cross has tripled. It is reasonable to assume that in the next decade we should be able to almost double the number of persons who have prepaid hospital care and, at the same time, bring the levels of protection to a point where the full hospital bill is paid for by third party arrangements. This will mean that almost all hospital income for patient care will come from third party payments.

Harry Becker . . associate director of the Commission on Financing of Hospital Care and author of the accompanying article

The forgotten patients . . One of the significant gaps in population coverage by prepayment plans today is that, in general, the nonwage earners are excluded. This includes the public assistance groups, the unemployed, and retired workers. Also, coverage is lacking in most parts of the country for prolonged and chronic illnesses. All of our prepayment plans have important gaps in service, but the mechanism exists for closing these gaps and we can expect that over a period of time they will be closed.

Before the hospital administrator can provide the kind of service the public is demanding and before he can maintain his hospital program at the standard dictated by present day medical developments, he must receive payment on a basis which will cover cost of services rendered by his hospital. Moreover, until 95 per cent or more of all patients are prepaid, or whose care is paid by third party agencies, the hospital administrator may expect to have difficulty meeting his budget.

A dilemma . . Unfortunately, the dilemma he faces today is that with only 50 per cent of his patients prepaid he cannot expect this prepaid group to cover the deficits created by less than full payment for services rendered other patients. Nor can he expect the 50 per cent of his patients who are prepaid to carry the cost of training and research programs, capital replacement and expansion, and the full cost of such items as stand-by services. However, if all patients were prepaid or received care under third party arrangements, some of these indirect patient costs could be absorbed by the third party agency.

The greatest barrier to expansion of prepayment plans is the cost to the individual of prepaid hospital care. If the entire cost of indirect patient services were generally included in the cost of hospital care to the prepayment plan, the rate of development of voluntary hospital insurance would be seriously retarded. The hospital administrator must not be unmindful of the fact that the long range answer to most of his and the community's basic economic questions requires as rapid an expansion of our voluntary prepayment plans and an extension of satisfactory third party arrangements as can possibly be achieved. This is particularly true for marginal income groups.

To succeed, these plans must, in the next few years, improve their standards of benefits and expand their coverage to such groups as the unemployed and the aged. The increased monthly premium cost of such broader levels of protection as well as broader scope of coverage can be minimized in many ways. In cooperation with the third party agency, the hospital and the physician must take every measure, consistent with high standards of service, to reduced costs of care provided the prepaid patient. In financing acute inpatient care for prepaid patients, too much stress cannot be placed on the need to safeguard against unnecessary expenditures.

Controlling costs . . Increased operating efficiency within the hospital is a factor in the control of costs to the third party. Probably of more importance, cost-wise, in

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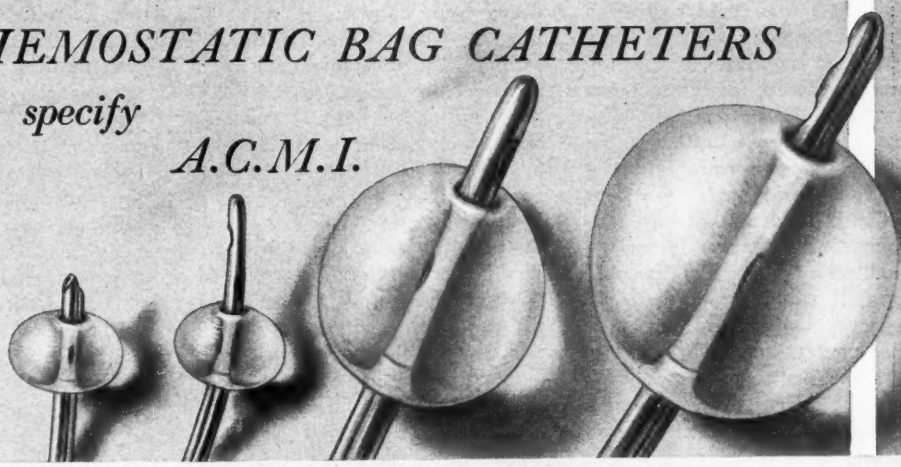

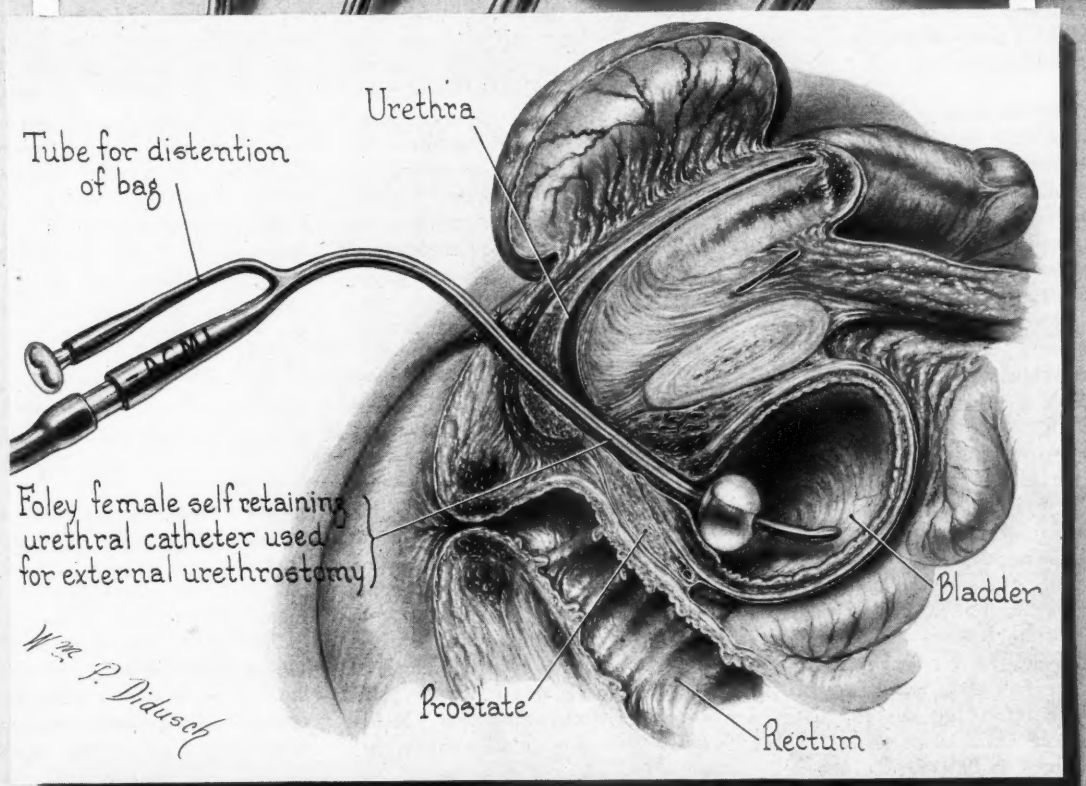

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NEW YORK 59, N. Y.

meeting today's economic problems would be such measures as the screening of patients to avoid admitting those who could be treated on an outpatient or home care basis. The establishment of procedures to assure early diagnosis and treatment, and prompt discharge when hospitalization is no longer necessary, is equally important. To illustrate, a ten per cent reduction in the length of stay, or a ten per cent reduction in use of hospital services per 1,000 prepaid patients, if possible and desirable to achieve, could mean almost a ten per cent reduction in the cost of care for the prepaid group for whom the third party agencies guarantee payments. Such savings mean greater economic security for the third party agency and in turn for the hospital.

A serious drag . . A serious economic drag on the hospital and on the community prepayment plan is the almost general practice of government, as a third party payer, to expect hospitals to pay for patients hospitalized at public expense on a basis that represents less than cost of care provided. This practice is unsound both for the hospital and the public welfare agency.

Public welfare administrators are finding increased resistance on the part of legislators to appropriate, in a period of full employment and high taxes, sufficient funds to maintain public assistance budgets at subsistence levels. Even harder is the task of getting enough tax money to meet the rise in hospital costs. We cannot expect the public welfare agency to interpret the economic changes in hospital operation to legislators without the help of hospital administrators, their board members, and members of the medical profession.

The hospital administrator and the prepayment plan executive must be concerned about the difficulties that public welfare officials face in obtaining the funds necessary to pay the cost of hospital care for their recipients. And hospital administrators must be concerned with the character and operation of the community prepayment plans. Too often, day-to-day responsibilities at the hospital seem more urgent than does the "time out" needed to meet with the executive of the prepayment plan to learn what help he needs from hospitals to make his program more effective as a public service. The prepayment plans cannot meet the public's need for hospital care or the hospital's need for adequate financing unless close cooperation exists between the third party and the hospital.

Call for understanding . . Whether or not these plans will develop into community agencies serving a major segment of the population depends to a very large extent on a mutual understanding, between the plan and the hospital, of respective interests and problems. The evidence is clear, for example, that the commercial insurance carriers are not going to be able, on a cash indemnity basis which pays less than the cost of care, to perform the job which is required for a sound community program for financing and developing hospital services. Hospital administrators and their boards must understand the basic differences, from a public and a hospital point of view, between the commercial cash indemnity plans and the non-profit service programs, and act accordingly.

Problems of payment to hospitals by third party agencies are many and complex. The hospital and the third party agency must find ways to resolve these problems in the interest of the public as well as in the interest of good hospital care. There is no reason, for example, why the amount of payment from the third party cannot be adjusted to meet month to month changes in cost and to provide funds for plant expansion and replacement. Methods of paying hospitals must be employed which will encourage . . not discourage . . development of improved programs such as rehabilitation and outpatient diagnostic and treatment services.

If the third party agency is going to underwrite hospital costs, the hospital must find ways to give the public and the third party assurance that its costs are being held within reasonable limits. Hospitals must be motivated to expand programs in a manner that is consistent with economy and efficiency.

New interpretation . . A shift to third party payments as the major source of income for the hospitals in a community means a new interpretation to the public of hospital as well as third party costs. Patients who pay their hospital bill directly tend to compare hospital costs on the basis of room charges or charges per admission. Prepaid patients, on the other hand, measure the costs of hospital care in terms of their monthly premiums for hospitalization insurance and not on the basis of hospital charges.

The implications of measuring hospital costs to the community by the monthly prepayments are many. The factors which affect the amount of monthly premiums are quite different from those factors which determine per diem costs. Although the per diem costs are an important factor, they are not the only important consideration in determination of monthly cost of prepayment. Utilization of hospital services per thousand persons covered is as important a cost consideration as per diem costs. In the future this and similar considerations, which evaluate hospital services in terms of the effectiveness of the protection and care provided for the whole community, will be used more and more as the measure of success of a hospital's program.

A new era . . We are on the threshold of a new era in hospital financing and development of hospital services. Hospitals as we know them today have been underfinanced since their inception. The gap between the best that we know how to provide and what is generally available to people everywhere is still larger than necessary. In the next decade, real progress will be made in closing this gap. More people are going to participate in monthly prepayment plans.

Whether we realize the potential that exists today for raising hospital standards and making comprehensive hospital services generally available depends on active cooperation and understanding by the public, the physician and the hospital of the underlying economic and social problems related to prepayment and hospital care. ■

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news from Washington

by Kenneth C. Crain

Easing of materials situation has benefits for hospitals

■ STEADY EASING of the scarce materials situation has been the outstanding fact in the Washington situation during the past month, although this had already begun then. Beginning, however, with a surplus of restricted materials due to unplanned delays in the production of various items in the rearmament program, notably planes, this has since been emphasized and accelerated by a formal announcement of a so-called "stretching" of the plan program to occupy a longer period than originally planned.

The immediate result, naturally, was a substantially lessened demand for virtually all of the materials needed in the program as at first laid out. Even copper, scarcest of all the scarce materials excepting nickel, has shown some significant indications of becoming a little easier to get, although as yet it is still far from plentiful.

Benefit to economy . . The entire economic fabric has benefitted from the relaxation in controlled materials, with the automotive industry as the outstanding example. With improvement week by week, the latest explicit encouragement to the industry came on Feb. 27, when a report got about that the N.P.A. had actually requested car manufacturers to plan to use 10 per cent more steel in the first quarter, two-thirds gone of course, than had originally been allocated, for the announced purpose of improvement of employment in the industry.

This way of putting the situation was not approved in Washington, where the authorities preferred to explain that car makers were asked to submit estimates of the extra materials they would need to reach a production level of a million cars in the second quarter. Be that as it may, it is a fact that the rapidity with which unemployment in Detroit and other automotive industry centers became serious played its part in the sincere effort of the government to restore the availability of materials when this became possible through the modification of the rearmament program. Similar results have been noted in other and smaller industries, although some remain in difficulties which will reduce employment and output.

Naturally, hospital construction and hospital equipment production have shared in the improved situation indicated, although in most instances, as previously reported, these vital aspects of the civilian economy had been pretty well taken care of in the efforts to control the uses of scarce materials. With the announcement of Feb. 25 that office buildings, stores, filling stations and all other types of commercial construction held up because of steel, copper and aluminum would be allowed to go ahead as soon as possible, it became evident that hospital planners were to be all but completely free of worry.

If they still have some difficulty in getting copper pipe and wire, and stainless steel, in which nickel is the essential component, that will have to be handled as circumstances may suggest; but there are few instances where essential equipment is not going to be available for hospitals new and old, and still fewer where the materials for new construction will not be available, provided the job has been properly placed before the authorities. The chances are that even in cases where this was not done the expanding facilities of the open market might prove adequate.

Approved building . . Twenty-four additional health center or hospital projects were approved for construction under the Hill-Burton program during the month of January, indicating the intention of the authorities to go ahead with the program; and it may reasonably be anticipated that this will be the picture month by month, barring serious developments in the world situation. So the consolidated picture of the government-aided hospital program as of the end of January presented an impressive view of the now vast magnitude of the achievements recorded to date.

The total number of all projects from the beginning is 1,735, with a total estimated cost of $1,320,377,503 and a Federal share of $473,138,729, and a total ultimate bed capacity of 83,152 in addition to the facilities provided by the 269 health centers included. Out of the total, 795 projects, with 27,967 beds, are in operation, 783 are still under construction, and 157 have been initially approved.

A more detailed statement of the recently announced decision of the Wage Stabilization Board not to limit what employers put into profit-sharing and pension plans made it clear that, with general approval,

continued on page 90

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the hospital calendar

List Your Meetings

As soon as the dates for the next succeeding meeting of an organization have been determined an official should forward those dates at once to Editor, Hospital Management, 200 E. Illinois St., Chicago 11, Ill. to insure appearance in this calendar.

March

17-21 . . AHA Nursing Service Institute, Boston.

17-21 . . AHA Dietary Department Management Institute, Cincinnati.

24-26 . . New England Hospital Assembly, Statler Hotel, Boston, Mass. Secretary, Theodore F. Childs, Brockton Hospital, Brockton, Mass.

25-27 . . Kentucky Hospital Association, Seelbach Hotel, Louisville, Ky.

27-28 . . AHA Safety Institute, Boston.

31-April 3 . . Blue Cross-Blue Shield Annual Conference, Fairmont and Mark Hopkins Hotels, San Francisco.

31-April 3 . . Ohio Hospital Association, Hotel Cleveland, Cleveland, O., Executive secretary, Harry C. Eader, 55 E. State St., Columbus 15, Ohio.

31-May 23 . . Hospital housekeeping short course, Michigan State College, East Lansing, Mich.

April

14-15 . . AHA Personnel Relations Institute, Atlanta.

16-18 . . Southeastern Hospital Conference, Atlanta Biltmore Hotel, Atlanta, Ga. Executive Secretary, R. G. Ramsay, Jr., assistant superintendent, Gartly-Ramsay Hospital, Memphis, Tenn.

21-22 . . AHA Public Relations Institute, Kansas City.

23 . . Iowa Hospital Association, Kirkwood Hotel, Des Moines.

23-25 . . Mid-West Hospital Association, President Hotel and Municipal Auditorium, Kansas City, Mo. Executive secretary, Anne Walker, 601 Pickwick Bldg., 903 McGee St., Kansas City 6, Mo.

24 . . West Virginia Hospital Association, Roanoke Hotel, Roanoke, Va.

24-25 . . Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va. Secretary-treasurer, J. Stanley Turk, Ohio Valley General Hospital, Wheeling, W. Va.

28-30 . . Tri-State Hospital Assembly, Palmer House, Chicago, Ill. Executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville 11, Ind.

May

1-2 . . AHA Operating Room Administration Institute, Chicago.

5-6 . . Arkansas Hospital Association, Arlington Hotel, Hot Springs, Ark.

8-10 . . Tennessee Hospital Association, Peabody Hotel, Memphis. J. M. Crews, president.

12-13 . . AHA Trustee Institute, St. Paul.

12-15 . . Association of Western Hospitals, San Francisco, Calif. Executive secretary, Melvin C. Scheflin, Association of Western Hospitals, 26 O'Farrell Street, San Francisco 8, Calif.

14-16 . . Upper Mid-West Hospital Conference, Lowry and St. Paul Hotels, St. Paul, Minn. Executive secretary, Glen Taylor, Students' Health Service, University of Minnesota, Minneapolis, Minn.

19-20 . . AHA Purchasing Institute, Atlantic City.

20 . . Connecticut Hospital Association, Southern New England Telephone Co. Auditorium, New Haven, Conn.

19-23 . . AHA Engineering Institute, Chicago.

20-22 . . Texas Hospital Association, Shamrock Hotel, Houston, Texas. Executive secretary, Ruth Barnhart, 2208 Main St., Dallas 1, Texas.

21-23 . . Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J. Convention manager, J. Harold Johnston, 506 E. State St., Trenton 9, N. J.

21-23 . . New Jersey Hospital Association, Convention Hall, Atlantic City, N. J.

22-23 . . New Mexico Hospital Association, Clovis Hotel, Clovis, N. M.

24-25 . . Catholic Schools of Nursing Conference, Public Auditorium, Cleveland, O. Secretary, Margaret Foley, 1438 South Grand Blvd., Saint Louis 4, Mo.

25-30 . . American Society of X-ray Technicians, Morrison Hotel, Chicago, Ill.

26-29 . . Catholic Hospital Association, Public Auditorium, Cleveland, O. Executive director, Rev. John J. Flanagan, S.J., 1438 South Grand Blvd., Saint Louis 4, Mo.

27-28 . . Idaho Hospital Association, Shore Lodge, McCall, Idaho. President-elect and program chairman, John L. Sundberg, administrator, Caldwell Memorial Hospital, Caldwell, Idaho.

June

9-13 . . American Medical Association, Chicago, Ill.

13 . . Indiana Hospital Association, Hotel Lincoln, Indianapolis.

16-17 . . ACHA Institute, New York City.

16-20 . . American Nurses Association, National League of Nursing Education, National Organization for Public Health Nursing, Atlantic City.

July

13-18 . . American Association of Hospital Accountants Institute, Indiana University, Bloomington, Ind. Secretary-treasurer, Frederick C. Morgan, The Genesee Hospital, Rochester 7, N.Y.

14-18 . . ACHA Southern Institute, Durham, N. C.

August

18-22 . . ACHA Midwest Institute, Boulder, Colo.

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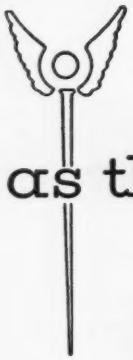


as the editors see it

What goes on?

■ THERE WAS AN ABLE and experienced hospital administrator some years ago who used to see to it that in the good-sized institution of which he was in charge every patient had at least one visit from him every week. It might be, it usually had to be, quite brief, but he got around; and the patients loved it. He was quite a story teller, with the art of the illustrative anecdote (they call it a parable in the Bible) down to a fine point, and in selected cases he would stop long enough to give the patient a few moments of amusement listening to a good story. On the whole, this part of the administrator's routine was one which he enjoyed as much as the patients did.

Advantages of supervision . . But there was a sort of major by-product of this business of visiting the patients which was actually so important in the eyes of the executive that it was in fact the basic reason for the whole procedure. He illustrated it often by telling the ancient story of the office boy who was heard in the corner drug store calling up the office where he worked and asking if they needed an office boy, hanging up well satisfied with the reply that no, they didn't need an office boy, they had a good office boy. Asked why this was done, the lad, wise beyond his years, answered: "I like to check up on myself." The hospital administrator felt very strongly the need for him to do a pretty regular and personal check up of what was going on in his institution, from top to bottom, from the operating suite to the kitchen.

He used to point out that it kept personnel of all grades acquainted with him in a real and personal way, which he correctly thought to be a good thing; and more than that, it kept employes throughout the hospital fully aware of the fact that the top man might be along almost any time. Direct supervision of course is the duty of the immediate superior; but for everybody concerned it is not a bad idea to know that the frequently too remote superior has an eye on the operation and means to keep informed about how it is being handled.

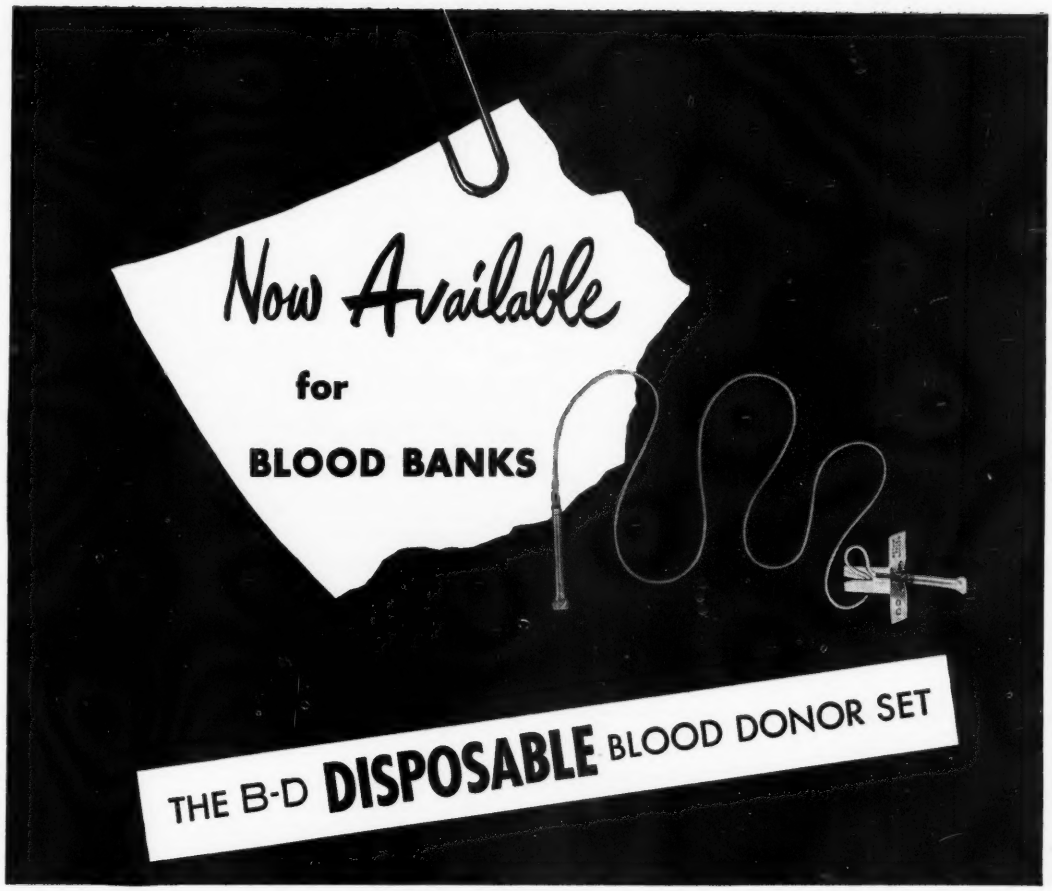
Sidelights on this sort of familiarity with the multiple activities going on in the institution are many and sometimes surprising. There is something to the remark which another widely known administrator used to make to the effect that nobody can run a hospital of more than 300 beds. The bigger the hospital the more complicated its operation becomes, in a great many ways, and more the demand it makes upon the care and competence of the administration at all levels.

Large hospital complexities . . But the chief point to the comment is that at a given point it is next to impossible for the person in charge to keep this intimate touch with what is happening, because it becomes a physical and time-consuming task beyond the practical necessities of the job. In that respect the executive of a small or medium-sized institution may very well consider himself (herself, usually) especially fortunate, since the interesting and desirable exploration of the hospital at frequent intervals is so relatively easy.

The executive first referred to used to tell, as an illustration of the things he ran into now and then which he wouldn't have liked to miss, of finding one day, during the midday period when lunch is going on, a distracted mother sitting in the lobby area with an injured child. It turned out that the youngster was not seriously hurt, but he might have been, and was still bleeding rather freely; and the mother, on the courteous approach of the administrator to inquire whether he could help her . . there was nobody else around . . told him that she had been waiting for attention for an hour.

What might have been . . She did not wait any longer. But the administrator would always pause to comment that if that child had died, as might have happened, he would have felt like shooting himself. It was in a first rate, well-managed hospital where this incident occurred, however, and but for the by no means aimless meandering of the top executive the incident could and would have been worse.

With the best of intentions and the best of supervision in all departments, which of course is the aim and object of good hospital administration, the things that have to be done, from the moment the patient enters the hospital to the day when he leaves, are in the hands of a considerable number of people, not all of whom are as careful and competent as they ought to be. The task of keeping people up to the mark in their work, of correcting negligence and oversight, is that for which supervision exists. It is a never ending job, as every hospital executive very well knows, and the surprising thing actually is that it is as a rule so well done that patients are comfortable and happy in the secure feeling that they are being cared for in the best possible fashion. But the top administrator can go far toward assuring himself that things are going well by the simple if sometimes irksome course of taking a look, right along. It is fine to know what is going on. It could have been, in the possibly tragic instance given, very painful not to know. ■



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Licensing nursing personnel

■ THE TENDENCY TOWARD statutory requirements for the licensing of all who "nurse for hire" seems to be increasing, judging by the number of recent reports of legislation on this line here and there; so it behooves hospital groups everywhere to see to it that proper exceptions for subsidiary nursing personnel in the hospital are inserted in such legislation, providing that such personnel, working under the supervision of professional nurses, do not have to be licensed.

Every now and then, if not subjected to a degree of friendly and expert supervision themselves, legislators blandly and blindly vote for something which in actual operation proves to be not only unnecessary, but downright impossible. Fortunately, in most states legislative committees of hospital organizations as well as of the nursing groups see to it that the law makers are kept pretty well informed and this task of information should be carried out in such fashion that conflicting views do not confuse rather than enlighten.

The licensing of professional nurses has of course been the rule for a good many years, but the licensed practical nurse is comparatively new. The effect of a licensing requirement which is too broad, so that it appears to apply to subsidiary personnel such as the nurse aide trained on the job in the hospital, may very well be precisely opposite to the intention and has in certain instances resulted in a sort of up-grading of subsidiary personnel to the level of the trained practical nurse. In fact, the liberalization of licensing requirements to bring in for approval all who have nursed for hire for a certain period, as automatically qualified, is a fairly usual procedure as a means of getting things started, so to speak.

The interest of hospital people in all this is the direct and simple one of seeing to it that their patients receive an adequate amount of necessary nursing care, since without this the hospital cannot do its work. Thus the increasing extent to which the use of subsidiary personnel is resorted to should not be handicapped by the imposition of licensing requirements.

Professional nurses themselves know better than anybody else how much their burden has been lightened by helpers who can readily be trained to do that 60 per cent or so of the duties once thought the exclusive function of the R.N.; and it is safe to say that no professional nurse would want to return to this situation. She needs and likes her aides, and as time goes on will undoubtedly lean on them more and more. Their use should not be made difficult or impossible by ill-considered licensing requirements. ■

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hm 25 years ago

■ THE MARCH, 1927 ISSUE of **'hm'** was, like this one, devoted primarily to building and construction. The *piece de resistance* was a seven-page feature by Dr. Harold Hays, director of The Park West, New York City. Entitled "For the Well-to-Do Patient Wanting Maximum Service," the article described the financing, building and operation of The Park West, a unique institution for those who could afford luxury.

"A properly organized company, along business lines, which is out to make a profit, is the only kind which will give the maximum of service in a private hospital," the author stated. He thereupon described the organization of two stock companies . . one a realty company to erect and equip the building and the other to rent the building from the former and operate it.

> Two or three points I considered of the greatest importance: 1st, To get as many stockholders as I could who would subscribe to from $1,000 to $5,000 worth of stock, rather than to get certain individuals to invest large amounts. 2nd, to interest as many doctors as possible, to make them feel that this was a good investment and at the same time to firmly impress upon them that they would use the hospital much more if they had money in it. The result of this plan was that I have about 170 stockholders, among all classes of people, who are advertising the place and 48 doctors own stock, almost all of whom are using the hospital as much as they can.

The layout of floors, room appointments and equipment are admirably described and illustrated.

■ "HOW ARE HOSPITALS to Obtain These Millions for New Buildings?" asked Mary Frances Kern . . a question that is apropos in 1952, which similarly sees a high level of new construction, remodeling and re-equipping. The author concluded that getting sufficient funds is not impossible when (a) the "public is properly approached," i.e., indoctrinated thoroughly in the importance of hospital service, and (b) a well-conducted campaign is organized under the supervision of a reputable fund-raising organization.

■ A SYMPOSIUM OF OUTSTANDING ARCHITECTS discussed the relative merits of the various shapes possible for hospital buildings. Richard E. Schmidt (Schmidt, Garden & Erikson, Chicago) favored a U-shape over a shape which has two courts. Isadore Rosenfield (Kidner & Rosenfield, N.Y.C.) concurred but deemed a straight-line-shape generally most suitable. Joseph Bell DeRemer, A.I.A. (Grand Forks, N.D.) was partial to the H-shape, while Henry F. Hoit (Hoit, Price & Barnes, Kansas City, Mo.) thought it was the poorest. Others considered the advantages of the L-, X- and V-shapes. ■

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who's who in hospitals

Administrators

Anderson, Victor . . Resigned as administrator, Abbott Hospital, Minneapolis, Minn., after 27 years with the hospital and its sponsoring institution, Westminster Church. He has been president of the Minnesota Hospital Assn., Minnesota Hospital Service Assn., and the Minneapolis Hospital Council.

Boyd, H. H. . . Appointed administrator, Leake County Memorial Hospital, Carthage, Miss., replacing **J. C. Taylor,** who resigned to resume his former position with the State Health Dept.

Brister, Marvin L. . . Appointed administrator, Martin County Memorial Hospital, Stanton, Texas.

Buehler, Mac . . Resigned as manager, McKay Memorial Hospital, Soap Lake, Wash., after 18 months in the post, to accept a position with Northwest Hospital Consultants, Inc., Spokane.

Cherry, John S. . . Named superintendent, City Hospital, Magnolia, Ark., succeeding **C. C. Cooper,** who has joined the faculty of the Southern State College. Mr. Cherry, a veteran of Army Medical Corps work during WW II, served for the past two years as superintendent, Desha County Hospital, Dumas, Ark.

Cockrell, Benjamin A., MD . . Appointed manager of the 300-bed V-A Tuberculosis Hospital, Memphis, Tenn., to succeed **Dr. Glen W. Doolen,** who is transferring to Central Office, Washington, D.C.

Cooper, C. C. . . see **Cherry** notice.

Corbitt, C. Whitney . . see **Smith** notice.

Doolen, Glen W., MD . . see **Cockrell** notice.

Eaves, Cyrus . . Appointed administrator, George County Hospital, Lucedale, Miss., succeeding **May Whitlow, RN.**

Rourke named executive director of N.Y. Hospital Council

Anthony J. J. Rourke, M.D.

■ DR. ANTHONY J. J. ROURKE, president of the American Hospital Association, has been elected executive director of the Hospital Council of Greater New York by action of the council's board of directors. He will assume his new duties the first of July.

Dr. Rourke has been physician-superintendent of the Stanford University Hospitals, director of the Stanford University Outpatient Clinics, professor of Hospital Administration at the Stanford University School of Medicine and lecturer in the School of Health at the University of California.

Previous posts included assistant superintendency of Vanderbilt Clinic, Columbia-Presbyterian Medical Center, N.Y.C., 1937-38, and the assistant directorship of University Hospital, Ann Arbor, Mich., 1938-40.

In making the announcement, Norman S. Goetz, president of the council, paid tribute to Dr. Rourke's "rich background in hospital, medical and community health affairs."

Fechner, Albert H., MD . . Appointed manager of the new 546-bed V-A Neuropsychiatric Hospital, Salt Lake City, Utah, which is scheduled for completion next month.

Franklin, J. B. . . Named administrator of the 200-bed Washington County General Hospital, now under construction at Greenville, Miss.

Gay, Daniel . . see **Hosford** notice.

Goochee, Ruth, Mrs., RN . . Tendered her resignation as superintendent, Port Allegany Community Hospital, Port Allegany, Pa., after 4½ years in the post.

Hodgson, N. W. . . Appointed administrator, Naeve Hospital, Albert Lea, Minn., replacing **Robert W. Wencil,** resigned. Mr. Hodgson formerly was administrator of the Bismarck Hospital, Bismarck, N.D.

Hosford, Raymond F. . . Named administrator, Lankenau Hospital, Philadelphia, Pa., succeeding **Daniel E. Gay,** who will serve as special consultant to the trustees for the construction of new facilities.

Kroeger, Hilda H., MD . . Named administrator, Elizabeth Steel Magee Hospital, Pittsburgh. Dr. Kroeger, a pediatrician, spent the last 3 years as assistant director of Grace-New Haven Community Hospital, New Haven, Conn.

Matthews, Dalton . . Named administrator, Cross County Hospital, Wynne, Ark., a 50-bed institution to open soon. For the past 9 years he has been superintendent of schools at Vandale, Ark.

McCord, Jack B. . . Named administrator, King's Daughters Hospital, Yazoo City, Miss., succeeding **Winston Whitfield,** who resigned the post to assist his father, **B. T. Whitfield,** in the management of the Corinth Hospital, Corinth, Miss.

Porter, F. Ross . . Departed last month on a 3-month tour of the Far East as a hospital affairs consultant to the U.S. P.H.S. and the E.C.A. Mr. Porter, who is chairman of the A.H.A. council on government relations, is superintendent of Duke Hospital, Durham, N.C.

Richardson, J. A. . . Named administrator, Stewart-Webster Hospital, Richland, Ga., succeeding **Mrs. Vivian Stair, RN,** resigned.

Sister Celestine, SC . . Appointed administrator, St. Vincent's Hospital, Philadelphia, Pa., succeeding **Sister Rita, SC.**

Smith, James D., MD . . Named acting administrator, the L. Richardson Memorial Hospital, Greensboro, N.C., until a permanent successor is selected for **C. Whitney Corbitt,** who resigned to become connected with Highsmith Hospital, Fayetteville, N.C.

Smith, Paul A. . . Named administrator, Navarro County Memorial Hospital and of Physicians and Surgeons Hospital, Corsicana, Texas. (Also see **Crump** notice.)

Stair, Vivian, Mrs., RN . . see **Richardson** notice.

Taylor, J. C. . . see **Boyd** notice.

Taylor, Ruth . . Resigned as administrator, Grove City Hospital, Grove City, Pa.

Wencil, Robert W. . . see **Hodgson** notice.

Whelply, Frederick G. . . see **Amicarella** notice under 'Assistant administrators.'

Whitfield, Winston . . see **McCord** notice.

Whitlow, May, RN . . see **Eaves** notice in this section and **Smith** item under 'Nursing posts.'

Woodside, Milton Henry . . Named administrator, Sampson Memorial Hospital, Clinton, N.C., succeeding **James DeVane** (see **'hm'** Feb. '52, p. 68). Mr. Woodside, a graduate of the Duke U. School of Hospital Administration, has been hospital analyst with the N.C. Medical Care Commission since 1949.

Assistant administrators

Ackerman, Rhea C. . . Appointed assistant administrator, Morton Hospital, Taunton, Mass. Miss Ackerman was formerly assistant administrator of Children's Hospital, Los Angeles, Cal.

Henry and Cousin shift duties in Rochester, N.Y.

■ APPOINTMENT of Joseph M. Henry, former director of Park Avenue Hospital, Rochester, as assistant director of the Rochester Regional Hospital Council, has been announced by Charles M. Royle, executive director of the council.

Cousin

Henry

Henry will succeed Jacques Cousin, whose resignation was announced simultaneously. Cousin revealed that he has been appointed administrator of the new Oakwood Hospital, now under construction in Dearborn, Michigan.

Upon separation from the Army in 1947 after six years of service, Mr. Henry attended Northwestern University for a year, taking a graduate course in Hospital Administration. Upon completion of that course in August, 1948, he came to the Regional Council as an administrative resident. During that residency he served first in the Council office, then at General Hospital, and, in February, 1949, he went to Park Avenue Hospital as acting director. In August of that year, after completion of his residency requirements, he was appointed administrator of the hospital.

Mr. Henry resigned from the Park Avenue Hospital position in April, 1951, and the following month was engaged by the directors of the new Placid Memorial Hospital, at Lake Placid, New York. He served in that capacity until January 1 of this year.

Upon separation from the Army in 1946 after four years' service, Mr. Cousin attended Columbia University graduate school, studying Hospital Administration, and then, in 1947, went to Harper Hospital, Detroit, for a year as administrative resident. Upon completing his residency he remained at Harper Hospital for another 18 months as assistant director of the hospital.

Amicarella, Henry . . Appointed assistant administrator, Evanston Hospital, Evanston, Ill., succeeding **Frederick G. Whelply,** who recently became administrator of Wyandotte General Hospital, Wyandotte, Mich. Mr. Amicarella, who has an M.A. (plus Northwestern U.'s M.H.A.), was a medical administrative officer in the Army from 1943 to 1946.

Callender, Eileen B., Mrs. . . Resigned as administrator, Alvin Memorial Hospital, Alvin, Texas, to become administrative assistant at Galveston County Memorial Hospital, La Marque, Texas. Prior to the Alvin connection, Mrs. Callender was hospital relations director for the Texas Blue Cross Plan.

Clegg, Reed L. . . Appointed assistant manager, V-A Hospital, Vancouver, Wash.

Crump, Winnie . . Named assistant administrator, Navarro County Memorial Hospital, Corsicana, Tex., now under construction. At present Miss Crump is supervisor of the Physicians and Surgeons Hospital there, which will be abandoned when the new hospital is ready for occupancy. (See also **Paul A. Smith** notice under 'Administrators.')

Ducker, Marguerite M. . . Appointed assistant director, Sewickley Valley Hospital, Sewickley, Pa., effective April 1. Miss Ducker has been serving as assistant director of the Program in Hospital Administration at Northwestern U.

Gibson, Eugene F., Jr. . . Assumed duties as acting administrator, Warren Candler Hospital, Savannah, Ga. He is on leave of absence from the Georgia Department of Public Health Services, Atlanta. Widely known in Southeastern medical circles, Mr. Gibson was formerly assistant administrative consultant in the division of hospital services.

Harvye, Osborne L. . . Promoted to post of assistant administrator, New England Center Hospital, Boston, Mass., after 4½ years as administrative assistant.

Heard, Corydon F., Jr. . . Appointed assistant manager, V-A Hospital, Little Rock, Ark.

Hoffman, Robert . . Named assistant superintendent (a newly created post) of Fergus Falls State Hospital, Fergus Falls, Minn. Formerly he was manager of the Litchfield Hospital, Litchfield, Minn.

Nursing posts

Monohan, Sylvia Merten, Mrs. . . Terminated connection as director of nurses and director of the Stamford Hospital School of Nursing, Stamford, Conn. Her successor is **Mrs. Mary Rigney,** who joined the school's faculty in 1949 and has served as educational director.

Smith, Sarah, Mrs., RN . . Resigned as administrator, Greene County Hospital, Louisville, Miss., to become superintendent of nurses at the Wayne County General Hospital, Waynesboro, Miss. Her successor is **May Whitlow, RN.**

Rigney, Mary, Mrs. . . see **Monohan** notice.

Weddige, Dorothy . . Appointed director of nursing education and nursing service of the Department of Hospitals of New York City. A graduate of the Bellevue School of Nursing, Miss Weddige has been with the agency since 1925.

Miscellaneous posts

Bray, Helen, Mrs. . . Won the 1951 National Award as "Outstanding Aide to the Mentally Retarded," for her initiative and skill in bringing a family life substitute to the mentally retarded children under her care in the Pacific Colony State Hospital, Los Angeles, Cal. The award, given by the National Association for Mental Health, consists of a $500 first prize, a gold pin and an award certificate.

Chionsini, Dorothy L., Mrs. . . Accepted position of accountant, Galveston County Memorial Hospital, La Marque, Texas. Mrs. Chionsini was formerly employed in the accounting department of the John Sealy Hospital of the University of Texas School of Medicine, Galveston.

Eichelberger, Mary E. . . Appointed personnel director of Evanston Hospital, Evanston, Ill. Previously Miss Eichelberger held a like post at San Joaquin General Hospital, Stockton, Cal.

Melgaard, J. Marie . . Appointed chief dietitian, Chicago State Tuberculosis Sanitarium, Chicago, Ill. Previously, Miss Melgaard, who is the editorial director of Hospital Management's "Food and Dietetics Department," was director of the dietary department of the Evangelical Hospital, Chicago.

Robinson, Chloe . . Named chief administrative dietitian, Galveston County Memorial Hospital, La Marque, Texas.

Board presidents

Borland, John Jay . . Elected president of the board, Children's Memorial Hospital, Chicago, succeeding **John P. Wilson,** who has held the post for the last 25 years.

Epp, Charles . . see **Nottberg** notice

French, Leon H. . . see next item

Childs succeeds Hayes as Lenox Hill head

■ THEODORE F. CHILDS, superintendent of Brockton Hospital, Brockton, Massachusetts, since June 1945, will assume the position of superintendent of Lenox Hill Hospital, New York, on April 1st.

John H. Hayes, superintendent of Lenox Hill Hospital, will then assume the position of director, to devote his time to improving the hospital facilities, planning rebuilding, and public relations activities.

Goss, Chauncey P., III . . Elected president of the Waterbury Hospital, Waterbury, Conn., succeeding **Leon H. French,** who served in the post for the past 4 years. Mr. Goss is vice-president of the Scovill Manufacturing Company.

Ledyard, A. C. . . Elected president, Children's Hospital of Michigan, Detroit, Mich.

Nottberg, Gustav . . Elected president, Research Hospital, Kansas City, Mo., succeeding **Charles Epp,** who remains a director.

Wilson, John P. . . see **Borland** notice

Deaths

Carmichael, Francis A., Sr., MD, 80 . . Former superintendent (1913-36) of Osawatomie State Hospital, Osawatomie, Kans. and of St. Joseph State Hospital, St. Joseph, Mo. (1941-46). An authority on mental illness, Dr. Carmichael was a member of the A.M.A., the American Psychiatric Association, and past president of the Kansas-Missouri Neurological Association and of the Kansas State Medical Society.

Christian, Charlotte, 81 . . Former superintendent (1909-29) of Passavant Hospital, Chicago, where she continued to hold an administrative post until her retirement 4 years ago.

Cousins, William L., MD, 81 . . Founder and owner of the former St. Barnabas Hospital, Portland, Me. He was one of Portland's best known surgeons before illness forced retirement in 1921. On Feb. 16.

Henry, Alfred E. . . Former administrator, St. Luke's Hospital, Fargo, N.D. After a heart attack; in Mexico City, Mexico.

Kemp, M. W., MD, 57 . . Superintendent of Madison State Hospital, Madison, Ind., since 1947. While undergoing surgery at Louisville, Ky.; on Feb. 6.

Leader, Helen J., 64 . . Directress of nurses, Presbyterian Hospital, Philadelphia, Pa., since 1936. After a cerebral hemorrhage; on Feb. 27.

Newell, Charles B., 46 . . Administrator and business manager of the University of Kansas Medical Center. Past president of the Kansas Hospital Assn. (1947 and 1948), and of the Mid-West Hospital Assn. (1949), Mr. Newell was a member of the A.C.H.A. and active in Blue Cross-Blue Shield organizations. Of a heart ailment; on Feb. 15.

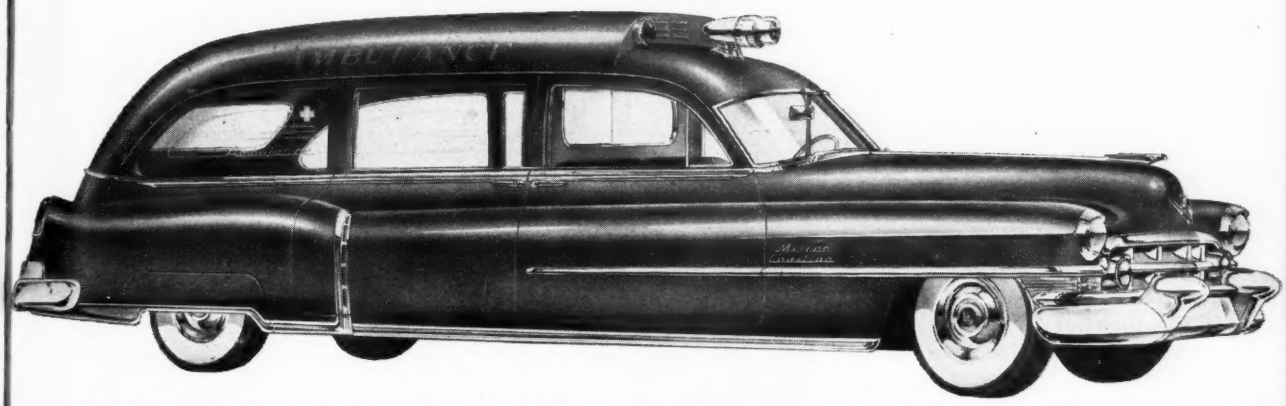
O'Brien, Francis E., MD, 56 . . Retired superintendent, Hampshire County Sanitarium, Northampton, Mass. He had headed the institution for 30 years, retiring Feb. 1. Nationally known for his work with TB patients, Dr. O'Brien was one of the first members of his profession to endorse surgery for the disease. After a long illness; on Feb. 15.

Clinic managers triple membership

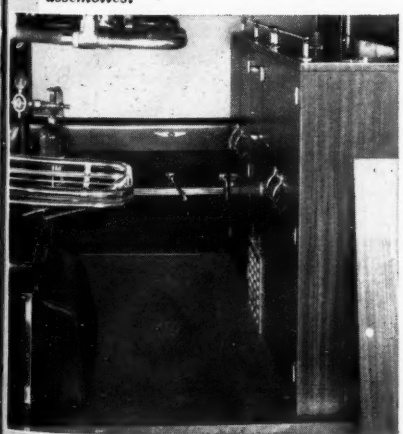
■ THE NATIONAL ASSOCIATION of Clinic Managers, which now represents 223 medical clinics, has tripled its membership in five years, the chairmen of the standing committees were told at a Chicago meeting Feb. 9 and 10. The association's twenty-sixth annual meeting will be Sept. 28 to Oct. 1, 1952 at the Palmer House, Chicago, Ill.

The association will sponsor a two-day institute at Wichita, Kans., May 23-24, at which there will be discussions on clinic organization, public relations in the medical clinic and financial controls in group practice. The education committee also reported on a graduate training program in clinic management at the State University of Iowa under the direction of Dr. Gerhard Hartman. ■

Demanded by Ambulance Operators for Heavy Emergency Use...



Built-in bunk for five seated or one reclining patient. Three more reclining patients may be accommodated by standard ambulance cot and two stretchers with hanger assemblies.



Head rest on built-in cot drops to permit access from side door to medicine cabinet and resuscitator.

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gifts to hospitals

"He that hath pity upon the poor lendeth unto the Lord; and that which he hath given will He pay him again." (Prov. XIX, 17.)

B.P.O.E. "Does" . . presenting checks to winners of nursing scholarships in Ogden, Utah. Shown with the students are Mrs. Louie Johnson, past president, and Mrs. Bessie Naef, current president.

■ OGDEN, UTAH, "DOES" (affiliated with the Benevolent and Protective Order of Elks) annually contribute two nursing scholarships to a pair of apt and promising girls. The scholarships, which are worth $150 each, are to the schools of nursing at St. Benedict's and Dee hospitals, in Ogden. They do much in providing a "lift" that encourages students to become efficient nurses.

Wollman million assures pavilion for children at N.Y.U. hospital

■ KATE WOLLMAN, who gave $600,000 in 1949 for a skating rink in New York City's famed Central Park, has again proved a benefactor to the city's youngsters.

The William J. Wollman Foundation announced last month that at Miss Wollman's request it would contribute $1,000,000 for the Children's Pavilion in the new building planned for University Hospital, which will be the largest of an eventual half-dozen major structures in the New York University-Bellevue Medical Center. The pavilion will occupy the eighteenth floor, with its own entrance near the corner of First Avenue and Thirty-second Street. It will have 60 beds as well as outpatient facilities.

Philadelphian leaves estate of $3,000,000 to charity

■ T. MUNROE DOBBINS, member of an old Philadelphia family, bequeathed almost his entire estate, valued at more than $3,000,000, to charity. His will contained gifts totaling nearly $700,000 to 25 religious, charitable and civic institutions, while personal bequests to relatives, friends and employes reached $200,000.

The residue, which bankers expected to exceed $2,000,000, is to be divided between the Home for Consumptives and the Episcopal Hospital, both of Philadelphia. Under direct bequests, the hospital will also receive $125,000 and the home $25,000.

Other gifts included $125,000 to the Burlington County Hospital, Mount Holly, N.J.

Whopping over-subscription to Canadian fund campaign

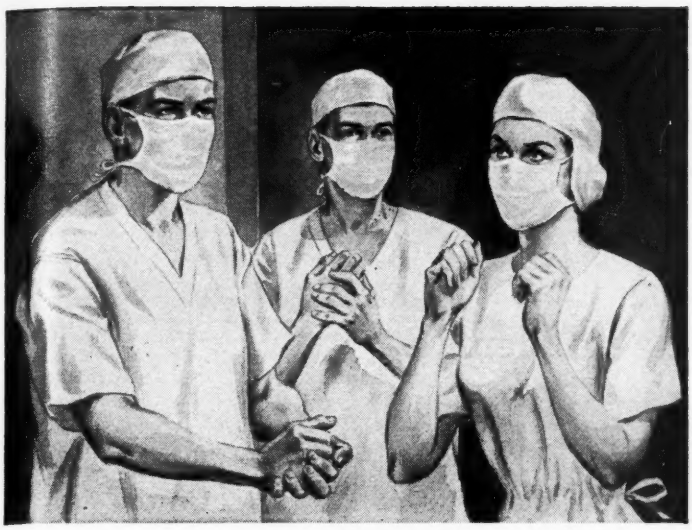
■ TORONTO'S GENERAL HOSPITAL set out in January to raise $14,000,000. The campaign closed last month with the fund over-subscribed by more than $2,000,000.

E. P. Taylor, general chairman of the promotion, revealed that $16,128,134 in pledges and gifts were collected for the hospital's rebuilding and modernization plan. This was believed to be the largest sum ever raised for a single hospital in Canada, surpassing by a considerable amount the $8,000,000 which was raised two years ago for the new building of the Toronto Hospital for Sick Children.

Expenses connected with the campaign totaled less than $125,000 . . a saving of $25,000 on the $150,360 budget.

Newport Hospital receives recovery room and equipment

■ A GIFT OF $10,000 for building and equipping a post-operative recovery room was bestowed on the Newport Hospital, Newport, R.I. The money was given by former Governor and Mrs. William H. Vanderbilt in memory of his mother, Mrs. Ellen French Fitz-Simons. ■



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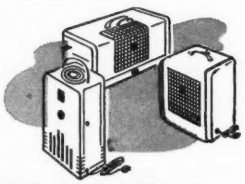
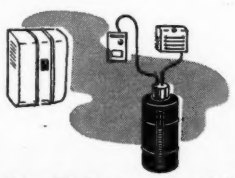
Your Airkem supplier will be glad to help you obtain the most economical and most efficient odor protection for your hospital. Call him today or write to Airkem, Inc., 241 East 44th Street, New York 17, N. Y.

Airkem Mist dispenser for sudden or "emergency" odors.

Airkem Wick Bottles service approximately 100 sq. ft. Tamperproof wall cabinets available for permanent locations.



Airkem Osmefan H-2 treats approximately 300 sq. ft. . . . Airkem Osmefan V-4—approximately 600 sq. ft. . . . Airkem Osmefan H-8—approximately 1,000 sq. ft.



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hospitals and the law

Sanguine problems ..

by **Emanuel Hayt** Counsel, Hospital Association of New York State

Release signed in advance by blood donor held valid

■ FOR THE FIRST TIME, a court has passed upon the validity of a release signed by a blood donor in advance of the donation of blood.

At the time in question, as well as on several previous occasions when he had given blood, he signed a statement exculpating the commercial blood supplier from any consequences from the giving of the blood and released any claims that he might have "by reason of any matter relative or incident to such donation of blood." He claimed that he suffered injuries due to negligence in not properly caring for him after he gave blood; that the release was against public policy.

The court did not agree with his contention. There are several well defined classes of cases, said the court, where similar types of releases have been declared against public policy and unenforcible. For example, an employe cannot be held to a release given to his employer relating to injuries resulting from his employment, because there must be no relaxation of the rule of law which imposes the duty of care by the employer toward the employe. Similarly, where the relationship involves a public service, it is against public policy for the public service to exempt itself from liability. The basis of this rule is that the parties are on an unequal footing. However, a blood donor does not come within any of these exceptions. He does not have to give his blood. He voluntarily chooses to do so. He is not employed in the usual sense of the relationship. Rather, he is an independent contractor who could give his blood or not, as he wishes, depending on the consideration offered by the buyer. The defense that the blood donor signed a release in advance of the donation is sufficient in law. (Boll *v.* Sharp & Dohme Inc., Supreme Court, New York County, Special Term, Part III, Hecht, J., *New York Law Journal,* September 17, 1951, page 501.)

State not liable for jaundice due to health dept. plasma

■ IT HAS BEEN HELD that the State of New York, acting as a distributor of pooled blood plasma, was not liable to the estate of a patient who had contracted homologous serum jaundice through transfusion of pooled blood plasma ordered by the attending physician.

The patient had been admitted to a voluntary hospital after having been picked up unconscious on the road. The resident physician prescribed shock therapy and a transfusion of pooled blood plasma. A week later, the patient left the hospital and returned to his employment after a period of convalescence. Three months later, he was re-admitted to the hospital suffering from homologous serum jaundice or hepatitis and died 11 days thereafter. His death resulted from the fact that the plasma had been infected with the jaundice virus.

The plasma was war surplus blood plasma which had been originally procured for the Army and Navy by the American Red Cross. The particular plasma administered to the patient had been shipped to the local branch of the Red Cross, which stored the material and delivered it untouched and in its original package to the hospital in response to a request communicated to the County Health Commissioner who had been designated by the State Commissioner of Health as District Laboratory Supply Station Custodian.

It was the contention of the administrator of the estate that the State, having knowledge of the incidence of homologous serum jaundice due to the use of pooled plasma, was guilty of negligence in the distribution of the Red Cross plasma and that it was at fault in failing to warn physicians of this danger; that the Red Cross plasma should have been irradiated and that if the plasma had been so processed, the incidence of the disease would have been materially reduced; further, that the State was remiss in failing to affix a warning label to the plasma carton.

The State Court of Claims of New York dismissed the case, holding that the State was not at fault because the physician had decided, in his judgment, to administer plasma. The danger of serum jaundice, known to the State, was well known also to the medical profession; it was not until April, 1949, some months after the patient had died and after some prior experimentation, that the use of irradiated plasma was generally accepted by the medical profession.

There is no warrant, added the court, for the assumption that the State had an obligation to instruct licensed physicians in the proper application of therapeutic agents in common use. (Parker *v.* State of New York, 105 N.Y.S. 2d 735)

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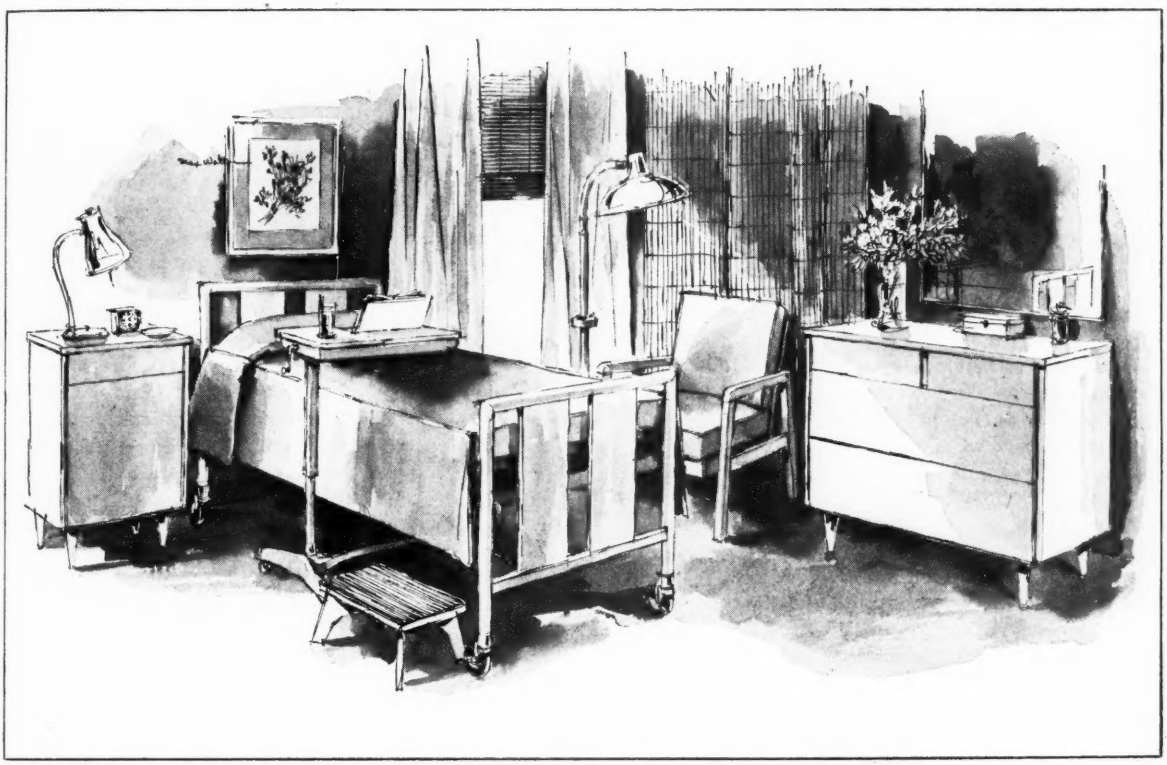

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of hospital interest

CLINICAL SONNETS. By Merrill Moore. Twayne Publishers, Inc., New York 4. 72 pp.; $2.50.

■ ANOTHER VOLUME has been added to the series of Dr. Moore's intelligent and witty books of verse for the adult and urbane.

Purists may wince at the poet's ultra-liberal interpretation of the sonnet form, since the Moorean "sonnet" has very little in common with the Shakespearean and Petrachian models . . not even a length of 14 lines. But the content is Life . . and real people . . which is more than can be said for most past or current sonneteering.

The Boston psychiatrist has recorded . . for our amusement or edification (or both) . . a gallery of portraits which is able to induce the *catharsis* usually effected only by the drama or by a sustained performance like the novel.

In his introduction, Dr. Moore recounts, "One of my friends said, after he had read this book in manuscript form: 'I don't see anybody here that I know. You must know a lot of very peculiar people.'" His comment on this is: "I do, and I think they would have to be somewhat peculiar, otherwise I would not want to write about them. Still, if you gathered all the characters in this book into one place, you would have just the sort of crowd that might collect anywhere to watch a fire, or to witness the departure of an ocean liner."

Perhaps the following will whet the reader's taste for more:

One winter day, while travelling across the State

Into the washroom of a drab day-coach
He stepped and set down a battered travelling-bag;
He was middle-aged and looked very tired to me;
In his lapel he wore a Masonic button.

He took out a pint of whiskey apologetically
And offered me some which I politely refused
(On the grounds that I had been drinking Coca-Cola
While reading *The New Yorker*).
Then he said:

"I've lost my boy. He died suddenly
Down at Whitman working on the power dam."

He said, "You know I never really drink
But this kind of got me." His eyes were very red
And filled with tears as he gulped the liquor down.

"It wouldn't be so hard but my wife's been dead a long time.
He was a good boy, never gave me any trouble.
He looked like a million dollars in a bathing suit."

While the frankness of some pieces would not be appropriate for a convent library (*Quick* magazine calls the collection "Kinsey in verse . . ."), the book is heartily recommended as a stimulating blend of pathos, wisdom and humor.

—F. J. D.

STATIC ELECTRICITY IN HOSPITAL OPERATING SUITES: DIRECT AND RELATED HAZARDS AND PERTINENT REMEDIES. By P. G. Guest, V. W. Sikora and Bernard Lewis. 64 pp., plus charts and illustrations. United States Department of the Interior, January, 1952.

■ THIS IS THE long-awaited "Report of Investigations 4833" by the Bureau of Mines, covering intensive research in 14 representative hospitals for the purpose of exploring as fully as possible the causes of explosions in hospitals, usually due to a static spark in the presence of an anesthetic gas, and the efficacy of various means of preventing such explosions.

As the Bureau comments, "recommendations range from such simple expedients as spreading wet towels on the floor and letting them touch the bases of operating tables and anesthesia machines to far-reaching changes in equipment and furnishings and exclusive use of cotton uniforms and gowns by all persons on duty during the administration of anesthetics," adding that "Tests confirmed that synthetic fabrics have a strong tendency to 'manufacture' static electricity."

The authors, all of whom are employes of the Bureau of Mines with highly-specialized background and experience in engineering and chemistry, go into all possible technical detail regarding the fashion in which static electricity is generated and accumulates, with numerous examples of specific cases, and with diagrams illustrating the process.

The specific recommendations (pp. 63 and 64) for the prevention of these explosions are ten in number, and cover in detail the suggestions regarding the types of equipment, clothing and bed-clothing which should be used for the purpose of avoiding the accumulation and eventual explosion of static electricity. The extent to which these hazards routinely exist in hospitals throughout the country is such that every hospital should secure a copy of this exhaustive study and proceed as rapidly as possible to eliminate the danger to patients and personnel by following the recommendations offered.

—K.C.C.

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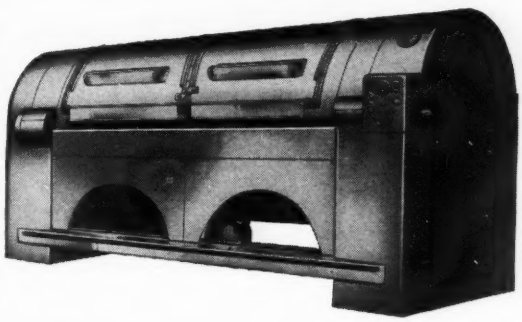

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Dr. MacEachern

continued from page 60

tant hospital should work for any less remuneration than in any other type of work and in order to pay such salaries the hospital must have an income to provide for them.

"Frankly I would much rather deal with an organization of our own in which we have something to say, than I would with any other type of organization in which we have no control or nothing to say about its operation."

Dr. Benson regards Blue Cross and Blue Shield as the bulwark against government controlled medicine.

"We who represent the Protestant hospitals in Minnesota," he concluded, "have assisted materially in not only organizing our Plan but together with other non-Protestant hospitals have helped to maintain it to the extent that it is one of the outstanding benefits to the public and to our institutions. Blue Cross is not a Protestant movement although the idea emanated from a Protestant hospital. It is a hospital movement embodying all those whose real purpose is to provide care for those who are sick and injured."

Public relations . . Good relations between the hospital and the community begin when the patient enters the hospital and has a satisfactory experience, said Frank Hicks, executive editor of HOSPITAL MANAGEMENT. Before the patient enters the hospital he already has built up a point of view from what friends have said about the hospital. What hospital personnel do and say every 24 hours of the day is the stuff of which good or bad public relations are made.

The important paper by Charles G. Lavin, assistant chief, Division of Civilian Health Requirements, Public Health Service, Washington, D.C., on "How to secure critical building materials and supplies" is reprinted in its entirety beginning on page 54.

Methodists meet . . The problem of better health and better social welfare "must be solved by government and voluntary agencies working together," the National Association of Methodist Hospitals and Homes was told Feb. 20 at Cleveland by Dr. Karl P. Meister, executive secretary of the association.

"Mistakes made in England prove that government without the voluntary agencies cannot do it properly," he continued. "Both working together can solve the problem, keep the spirit of humanitarian service in the program and bring about the desired results in the highest standards of scientific, social and Christian welfare. . ."

Selected papers from the Methodist meeting will appear in early issues of this magazine. ■

Washington news

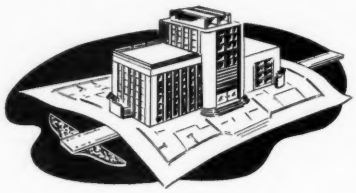
continued from page 70

these plans were not to be circumscribed as to scope even under circumstances making control of wage rises desirable. Closely allied to the same situation was the approval of hospital and related insurance plans operated by industry.

While, of course, these do not involve the substantial capital investment which is essential to the setting up of pension plans, nor the cash payments connected with profit sharing, their exclusion from wage-limitation regulations is sufficient indication of the place which they occupy in the esteem of wage earners as well as government. Blue Cross is not the direct beneficiary, but is in many cases the "carrier of choice," in the phrase of a leading labor welfare leader.

Hospital legislation . . As yet Congress has given little consideration to proposed legislation directly affecting hospitals, but the session is still young, and many things may happen before it is much further advanced, most of them unpredictable. The improbability of any action on any kind of compulsory health insurance continues, however, and just now it seems almost equally improbable that the Ewing effort to hitch a kind of health-insurance plan for those over 65 on to the existing Social Security system will be successful. So far there has not even been any measure for this purpose introduced, unless it has been done in the utmost secrecy; and if framed and introduced, it would certainly demand the most careful consideration in public hearings before any committee would venture to indorse it or any variation of it.

A measure which has received the qualified approval of hospital and nursing groups, the Bolton bill,



for a long range program of grants and scholarships in the field of nursing, may be moved along at this session. Representative Bolton commented recently that the chairman of the committee which held long hearings on the bill last summer had indicated the intention of scheduling H.R. 910, the Bolton bill, for early consideration in the hope of bringing it to the floor in the near future.

Mrs. Bolton continues to urge in support of her measure the known serious shortage in the number of professional nurses and the consequent difficulties of hospitals in keeping their beds in service, and with some of the proposed amendments limiting the scope of the

How do YOUR administration costs compare with those on page ten ?

measure, it might be expected that it would get through both Houses if it reaches the floor. The evident reluctance of Congress to keep up the program of increasing Federal expenditure in view of the rising concern of the public over the heavy tax burden may be an obstacle in spite of the relatively modest sums involved in the Bolton bill. ■

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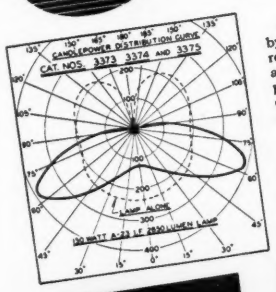

PERFORMANCE

Upward light from the lamp is redirected to useful downward light by the specular inner reflecting surface of the hood. This downward reflected light and the downward light from the lamp is bent upward and outward by the prismatic glass in the extended light distribution pattern shown on the Candlepower Distribution Curve. The radius of effective light coverage is upwards of three times the mounting height above the ground or floor.

APPLICATION

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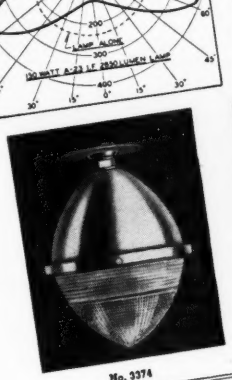
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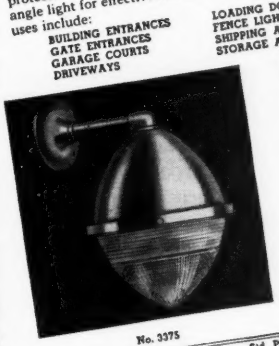
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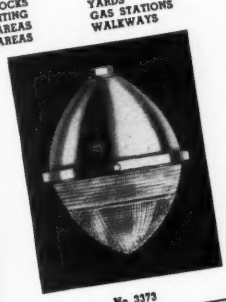
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No. 3373	7¾" Dia. Terminates in ½" conduit entry.	10" Deep O.A. Furnished with porcelain socket only.	150W A-23 Lamp	Std. Pkg. 4	App. Wt. 18
No. 3374	7¾" Dia. Terminates in a self-aligning cover for attachment directly to the ears of a 3¼" or 4" outlet box. The 20° swivel action permits installation on sloping surfaces. Wired with No. 16AF wire with 6" leads.	11" Deep O.A.	150W A-23 Lamp	Std. Pkg. 4	App. Wt. 21
No. 3375	Wall Clearance 3½". Terminates in a wall plate for attachment directly to the ears of a 3¼" or 4" outlet box. Wired with No. 16AF wire with 6" leads.	Extends 11¾" O.A.	Depth 10½" O.A. 150W A-23 Lamp	Std. Pkg. 4	App. Wt. 24

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Lamp position—vertical (150W Max.) A-23.

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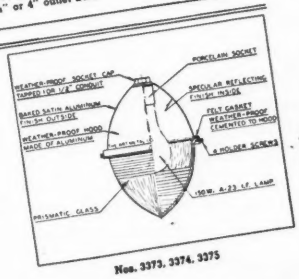
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The Department of Nursing Service is under the editorial direction of Dina Bremness, superintendent, Glenwood Community Hospital, Glenwood, Minn.

nursing service

What is public vocational education doing to train practical nurses?

by **Florence Slown Hyde** • Hospital public relations counsel

■ NURSING EDUCATION LEADERS generally are on record as favoring the sponsorship and control of practical nurse training programs by public school systems in preference to programs conducted entirely by hospitals. Vocational education leaders on the national and state levels have shown a willingness to cooperate in setting up such programs with the aid of government funds, wherever the local community has been ready to assume its share of the financial outlay and demonstrate its belief that the training of people to care for the sick is just as important as training people to become good farmers or good auto mechanics.

However, in 1951, according to "Facts About Nursing," the Federal Office of Education reported that there were just 113 practical nurse training programs in the entire United States and territories operating in vocational schools. Information collected recently from various sources by the writer indicates that there are approximately 75 state-approved practical nurse training programs sponsored by public vocational education in states that have practical nurse licensure or similar laws, with the approval status of a number of others pending in states that enacted licensure laws in 1951. In addition, six vocational training programs for practical nurses are listed by the National Association for Practical Nurse Education as having received its approval in states that have not yet enacted legislation for the licensure of practical nurses or similar groups.

Thus it is obvious that not all of the 113 practical nurse programs receiving federal aid meet the requirements for approval under state licensure regulations, although they no doubt are providing training of value to their students and the respective communities. Among the latter are the 64-hour courses which are being given in some states to help fill the gaps in the qualifications of practical nurses who have been or plan to be licensed under waiver provisions of state laws.

64-hour courses . . In Illinois, where the waiver clause of the recently enacted licensure law requires that the applicant pass an examination "wholly or in part in writing," 64-hour courses as recommended by the National Association for Practical Nurse Education are being set up in several cities under adult vocational education sponsor-

Practical nurse graduates . . Dr. Hobart Sommers, assistant superintendent in charge of vocational education of the Chicago public schools, awards pins and certificates to graduates of the practical nurse school program

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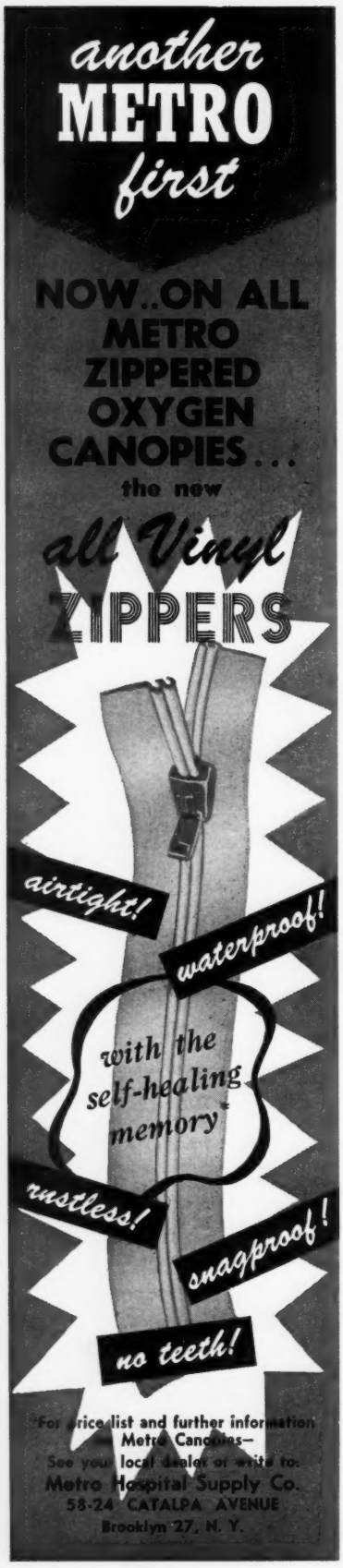

ship in response to popular demand.

Other types of practical nurse training programs which may qualify for federal aid include those conducted in high schools as part of the regular course but which do not rank as complete programs leading to licensure, although providing training which proves of basic value to those who later become nurses' aids or other auxiliary workers in hospitals. In fact, hospitals in some Illinois communities have cooperated in setting up and carrying on such programs with excellent results. No doubt similar programs are being carried out in other states.

Although it is possible to obtain federal aid for approved practical nurse training programs conducted as part of the regular high school course, a recent survey by the writer revealed that with few exceptions the state approved programs sponsored by public vocational education are adult education projects. Virginia reported two approved programs conducted in high schools and there may be a few others.

Commenting on the possibilities offered by the two types of programs, *Practical Nursing Curriculum* (Office of Education, 1950) states:

"The possibility of two sources of recruitment for practical nurse training programs is recognized. The out-of-school group ranging in age from 18 years upward will possess certain experience, skills, knowledge, habits, attitudes, and judgments pertaining to particular phases of practical nursing. These individual attainments must be evaluated and used for corrective teaching or for the introduction of new instruction. . . . . .

"Pupils who are nearing completion of their secondary school education and who will be of an eligible age to take licensing examinations and enter employment as practical nurses upon completion of their training provide another source of recruitment. This group will usually obtain their preparation in vocational school classes subject to many of the general standards and requirements established in the state plans for vocational education. . . . . In this type of training program, the clinical experience should follow the complete block of preclinical instruction offered in the vocational school."

Reasons . . Among the reasons given to the writer by both nursing and vocational education leaders for the preponderance of adult education programs over those set up as part of a high school course were the immaturity of high school students and the advantages of being able to utilize facilities and instructors to train a larger number of students in an adult education program.

Nevertheless, it is to be hoped that more practical nurse training programs of approved scope will be set up in high schools in order that their practicability may be evaluated. If, as suggested by the National Association for Practical Nurse Education, the preclinical course in practical nursing is given in the senior year, and is followed immediately by the clinical experience in a hospital, the graduate would in most instances not have long to wait for licensure, especially in the 20 states which set 18 years as the licensing age, or in California where vocational nurses can be licensed at 17.

Reimbursement . . Whatever the type of program, federal aid and, as a rule, state aid consist only of reimbursement for a portion of the salaries paid to faculty members. This varies in different states because of the leeway allowed in selecting the fields of vocational training for which the state allotment of federal funds may be used, but may be slightly more or less than 50% of the salary outlay. Nurse training programs have to compete with many other types of vocational education in obtaining funds on both the state and local levels.

All vocational practical nurse programs have affiliations with one or more local hospitals for clinical experience and instruction. This usually follows completion of the preclinical portion of the course. In this connection *Practical Nursing Curriculum* states on page 2, "Instruction will be more effective when the clinical training is offered following each segment of class-

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room instruction, but this procedure may not always be practicable from the standpoint of school administration, and it may be necessary to have the entire program of class and laboratory instruction precede the period of clinical training."

With few exceptions hospitals that provide clinical experience in connection with vocational school practical nurse training programs, pay stipends or provide maintenance or both to students. Where no maintenance or perhaps only one meal is provided, the cash payment is larger, ranging from $3.00 to $5.00 per day in different areas. In some programs, students are given a choice of full maintenance at the hospital or a cash stipend, the latter being preferred by those who have home responsibilities and to whom cash payments mean more than room and meals away from home. In many programs the amount of cash payment is increased from month to month as students become more proficient in bedside nursing skills.

Length of course . . The length of the approved course varies in different states in accordance with state laws or regulations of approving authorities. Although laws of 14 states set nine months as the minimum length of the course, regulations in several of these states recommend a 12-month course. In all but one of the other states having licensure, either the state law or the regulations of the approving authority sets 12 months as the minimum length of the course. On this subject, *Practical Nursing Curriculum* states:

"It would be unwise at the present time to make a definite recommendation regarding the exact period of time required for the satisfactory completion of the program of instruction outlined in this bulletin." Continuing, the bulletin points out that many of the schools which have been in operation for several years have operated on a 9-month to 12-month basis, while another limiting factor is the general point of view that it will be difficult to recruit mature students if the course exceeds one year because of the lost earnings involved.

Another paragraph states, "Regardless of the length of the program, the portion of time devoted to preclinical classroom and laboratory instruction should consume one-third of the total training period and about two-thirds of the total time should be devoted to training and varied clinical experiences in approved institutions and home situations."

Vocational schools do not charge tuition for students who are residents of the school district or other political unit maintaining the school. However, students in these programs provide their own uniforms and other individual equipment and usually some small laboratory fees are charged. No maintenance is provided during the preclinical training period, practical nurse stu-

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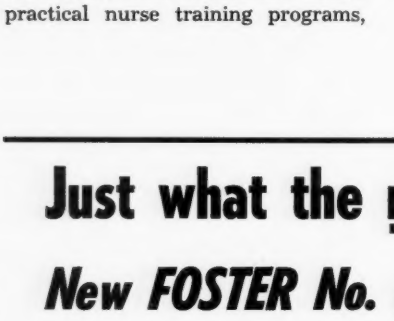

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dents being on the same basis as other vocational students in this regard.

In some states training programs are set up on an area or statewide basis under the adult education system, thus eliminating the payment of tuition by those within the area or the state. It is also possible for school systems within a given area to cooperate in sponsoring a practical nurse training center, although this involves much spade work at the outset.

Objectives . . The first obstacle to be hurdled in setting up a practical nurse training program as a public vocational education project is to convince the school authorities that it will meet a community need and that it has the backing of public opinion. This is usually accomplished through the initial sponsorship of some influential group and the formation of a strong advisory committee with representatives from the local hospital or hospitals, medical and nursing professions (including practical nurses), general and related education, and lay people representing community interests. This committee will develop plans and policies in cooperation with the school authorities.

The National Association for Practical Nurse Education states in its booklet, *Practical Nurse Education*, "that the initial costs of preparing and equipping a teaching suite may vary from $2,500 to $5,000, depending upon plumbing, lighting, and structural changes required." Other factors in determining the initial expense will be the existing facilities that are available in the local school system, such as food preparation laboratory, assembly room, and office, library and storage space.

The yearly budget will include salaries of the professional nurse in charge of the program, one or more nurse instructors, nurse supervisor of clinical practice, secretarial service, supplies of various kinds, books and periodicals, laundry service, and other expenses involved specifically in carrying on the program. The school authorities also may want to evaluate the cost of providing heat, light and janitor service for the

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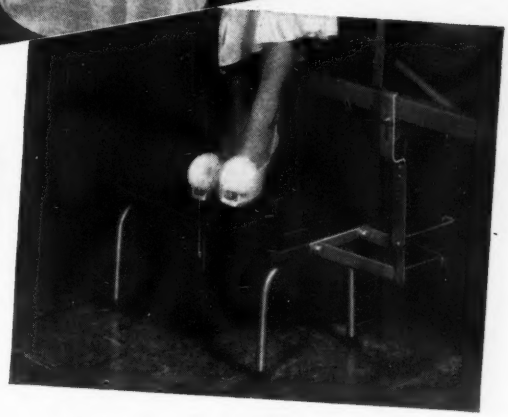

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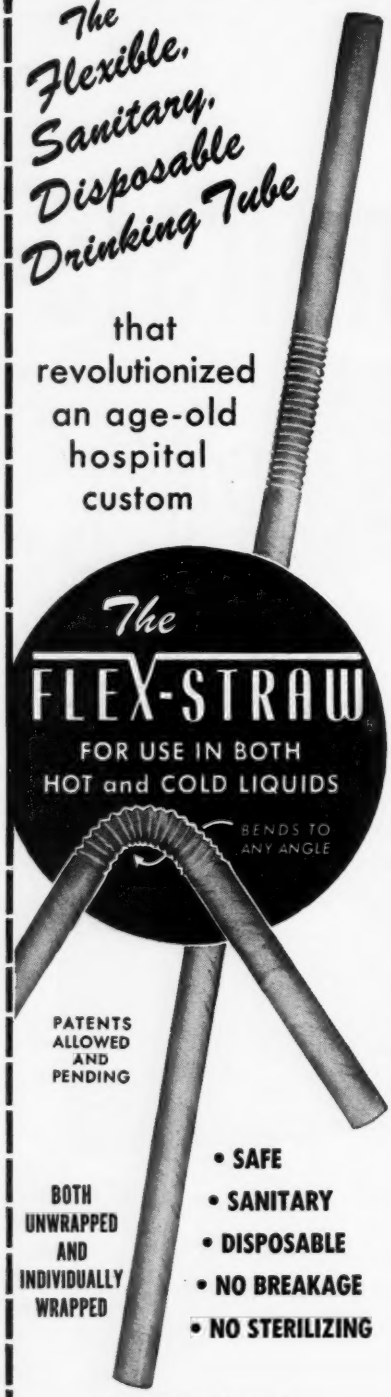

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areas used by the practical nurse training unit.

Nursing education leaders recommend that one clinical supervisor-instructor be provided for each group of 10 practical nurse students, that such person or persons be members of the vocational school's practical nursing faculty, and that their sole responsibility in the hospital be "the supervision of nursing practice and associated teaching for the practical nurse students." At the same time they are to be regarded as members of the hospital nursing staff and should participate in staff meetings. Obviously, such a setup could result in many difficulties in the administration of nursing service in the hospital unless there is a very clear understanding about the nursing service to be rendered by the students.

Community interest . . In some communities the initial expense for equipping the practical nurse training unit has been underwritten by organizations or individuals who are interested in doing something constructive to help increase the present short supply of nurses. This affords moral as well as financial support for the project and insures a continuing community interest in its success.

In a few communities facilities and/or space in a local hospital are being utilized for the entire course with salaries of instructors paid from public school funds. Notable examples of this plan are found in Norfolk, Virginia, and Pierre, South Dakota.

In Norfolk, the program is sponsored jointly by the vocational division of the Norfolk City Schools and Leigh Memorial hospital. The director of nursing service in the hospital is director of the practical nurse school, thus reducing by one the professional nurse personnel required. Her salary is paid by the hospital. Salaries of a full-time nursing arts instructor, full-time clinical instructor and the part-time instructor in food and home management are paid by the school board, which has also provided equipment in class and demonstration rooms, according to Mrs. Mildred L. Bradshaw, R. N., director of the school and the hospital nursing service.

Leigh Memorial hospital provides complete maintenance to the student and after the first month pays a stipend of $15.00 per month. The salary of a housemother is also paid by the hospital. Head nurses cooperate with the faculty in supervision and evaluation of clinical experience. The school was established in 1946, has 111 graduates, and a present enrollment of 22. It provides a 12-month program and is approved by both the Virginia state board of nurse examiners and the National Association for Practical Nurse Education. Leigh Memorial is a 173-bed general hospital, according to the 1951 directory of the American Hospital Association.

Incidentally, Mrs. Bradshaw contributed one of the most interesting comments received from any practical nurse school director. In addition to stating that the school of practical nursing has provided a regular source of trained practical nurses for employment in the home hospital, she says that the school has also contributed to improvement in nursing service by *"attracting a better prepared head nurse and general staff professional nurse. The registered nurse can function more effectively when she has the benefit of trained practical nurses to assist in the bedside care of patients."* "We feel," adds Mrs. Bradshaw, "that an understanding and evaluation of the practical nurse by the professional nurse staff is necessary to the success of this program. Our professional nurses work very harmoniously with both the graduate practical nurse and the practical nurse student."

Outstanding example . . An outstanding example of community support, both moral and financial, for a practical nurse training program as an adult vocational education project is found in Chicago, where the Council on Community Nursing spearheaded the effort to enlist the support of the Board of Education and obtained contributions from community sources to provide equipment for training centers in two of the city's vocational schools. Council members include

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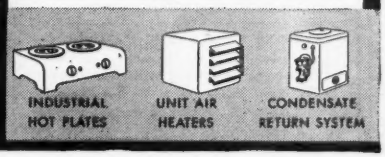

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professional nursing schools, medical, nursing and lay groups, and interested individuals.

Although the practical nurse training program has been a major project in recent years, the council has sponsored many other activities in the interest of better nursing care in the community, including the advancement of professional nursing education, student recruitment for both practical and professional schools, and a survey of nurse registries resulting in an approved list which has been made available to hospitals and the medical profession.

Inaugurated three years prior to the enactment of a practical nurse licensure law in Illinois, the Chicago program is the first to receive state approval under the legislation enacted in 1951. It had previously been approved by the National Association for Practical Nurse Education.

Practical nurse . . in training learning how to handle pharmaceuticals

Although the Illinois law permits a 9-month course as the minimum that may be given in an approved school of practical nursing, the Chicago program offers a 12-month course, including four weeks of vacation. The curriculum, as outlined by NAPNE, is followed in the main, with 16 weeks of preclinical instruction at the vocational school center, followed by 32 weeks of clinical experience and related instruction in one of six affiliated hospitals, all of which are approved by the American College of Surgeons and afford excellent clinical facilities. One, the Cook County Hospital, is also affiliated with a professional school of nursing, and another, Children's Memorial Hospital, provides affiliations in pediatrics nursing to several professional nursing schools. Students also have two weeks of home nursing observation with the Visiting Nurse Association.

No tuition . . Students who live in Chicago pay no tuition but must meet expenses of approximately $95 covering the cost of uniforms, textbooks, other individual equipment, and laboratory fees for nursing arts and food preparation courses. The tuition fee for students outside Chicago is $176, which represents the approximate instructional cost per student.

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Cash payments by hospitals during the clinical period total from $500 to $600 depending on whether the hospital provides students with one meal per day and some other perquisites, such as laundry of uniforms. The student has a 5-day, 40-hour week throughout the course, with hours adjusted during the clinical training so that some students are on duty in each hospital on Saturdays and Sundays. Aside from meals that may be furnished during the clinical training period, students provide their own maintenance.

The Chicago program is now being offered at centers in two vocational schools. Each center can admit a class of 50 students every four months, which means that a total of 300 students can enter training each year.

Miss Zella VonGremp, the professional nurse coordinator in charge of the program as a member of the vocational division staff, has both a B.S. and M.S. degree as well as other advanced preparation and teaching experience. Besides Miss VonGremp the full-time staff of professional nurses employed by the Board of Education to carry the training program at the two centers includes four classroom instructors, a fifth instructor who relieves during vacations since vocational school faculty members are on a 46-week basis, and a student counselor who also handles admissions and assists the coordinator with student records and hospital assignments. All of these staff members have B.S. degrees and advanced preparation and experience which fit them for their work both from the standpoint of nursing education and the standards set for vocational school faculty members.

Diet instruction . . The home economics instructor at each vocational school gives two hours daily to instruct practical nurse students in food preparation, including special diets. Secretarial service is also provided by the vocational school in which the offices of the coordinator are located.

General supervision of the clinical program is included in the responsibilities of the coordinator. Direct supervision of the hospital practice

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and the average of four hours of planned instruction each week are provided by a clinical supervisor employed by each hospital. The maximum number of students that are supervised by one person is 15, the preferred number being 10, a standard that cannot always be maintained in these days of professional personnel shortages.

Teaching facilities at each center include a nursing arts laboratory and a classroom for the teaching of related subjects. The former were equipped with funds provided by the Chicago Council on Community Nursing and rate as equal, if not superior to, nursing arts laboratories found in the better professional nursing schools. Structural changes were made at the expense of the school system.

The well equipped food laboratory used for other groups in each school serves this purpose for the practical nurse students, as do also lounge and rest room facilities and the assembly hall. Necessary office and storage space has been made available and each training center has space in the school library for its own collection of reference books and periodicals.

The age range for students is 17½ to 55 years. Educational prerequisite is two years of high school, with exceptions for those over 25 years who have completed the eighth grade and show evidence of intelligence and maturity. According to Miss VonGremp, older women prove to be excellent students, often better than some who are younger.

Beginning with a small enrollment at the Manley School center in September, 1948, and opening the second center at Princeton Continuation School in September, 1950, the Chicago program will have produced 298 trained practical nurses when the next class is graduated on April 17, 1952. Withdrawals average about 30%, which is less than the withdrawal rate in Illinois professional schools. Home responsibilities and economic problems are the principal factors that cause withdrawals.

Employment record . . A recent study of the 223 graduates who had completed the course through October 23, 1951, revealed that 134 were employed in hospitals, 37 were engaged in private duty nursing, 8 were employed in nursing homes, 8 were on staffs of public health agencies, 3 were in other types of nursing positions, 14 were inactive, and 19 failed to report. Graduates are in great demand to fill hospital positions and are found on the staffs of many of Chicago's best known hospitals.

Another vocational education program of particular interest is the statewide plan carried out in Connecticut for the training of attendant nurses as provided in the state law which licenses attendants. The 12-month training course and the duties performed by attendants are comparable to those of practical nurses in other states.

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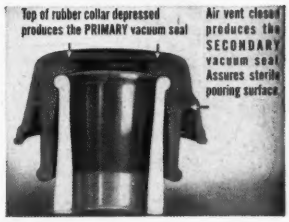
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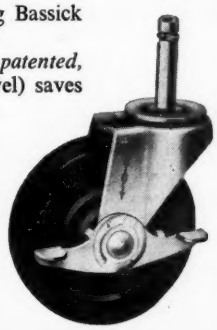

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The uniform course is sponsored by the Bureau of Vocational Education of the State Department of Education and is offered in three vocational training centers in cooperation with five hospitals, including such well-known institutions as Hartford Hospital at Hartford and Grace-New Haven at New Haven.

Students are admitted at each training center in January, April and September. A total of 135 students can be admitted each year. Students must be residents of Connecticut. No tuition is charged and the student pays only $34 for uniforms, provides her own white shoes and hose, other personal equipment and maintenance during the first three months of classroom work at the vocational center.

Hospital training . . Nine months are devoted to instruction and supervised practice in an affiliated hospital. During this period hospitals provide a board and room allowance and stipend totalling $55 per month, also meals when the student is on duty, and laundry of uniforms.

Hospitals recruit students, assemble credentials and participate with representatives of vocational education in approving applicants. They also employ a supervisor who is in charge of the trained attendant program in the hospital.

Students have a 7-hour, five-day week in the vocational school and a 40 to 48-hour week in the hospital. The age range for admission is 18 to 50 years. Applicants over 20 years must have had two years of high school, while those under 20 must be four-year high school graduates. The minimum age for licensing attendants in Connecticut is 19 years.

Miss Helen M. Marchant, R. N., the professional nurse supervisor of the trained attendant program throughout the state, reports that trained attendants are filling positions in many general hospitals, as well as in convalescent homes and that the demand far exceeds the supply. They also do nursing in private homes and according to reports from registries and physicians give service that is highly satisfactory.

Interesting features of practical nurse training programs sponsored by public vocational education in other states and facts about other developments in this newest field of nursing education will be presented in a future article by Mrs. Hyde. Watch for it. It may help you to solve your own problems of nurse supply.

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Correction

Attention is called to an inadvertent error in Mrs. Hyde's article in the February issue of Hospital Management. Please note that the paragraph titled "Accredited Schools" in col. 3, page 82, the first sentence should have read "Accredited schools in Minnesota include" etc. but that the words "in Minnesota" were omitted, thus failing to identify the location.—Editor

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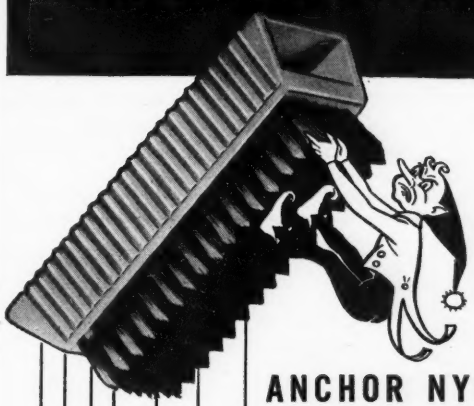

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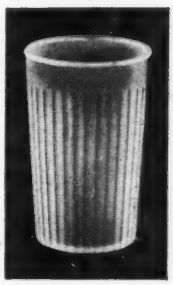

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Nursing teams as solution to shortage of nurses

by Harriet S. Phelps, R.N.
Superintendent of Nurses
University of California Hospital
San Francisco

■ ALL OF US who are concerned with health in our communities today are conscious of the shortage of personnel available to meet health needs. The ability to provide adequate nursing service for our patients in hospitals has depended on the availability of professional nurses. Nursing service has always implied, in addition to the complete functioning of the "ward" as a unit of the hospital, actual bedside care of the patient.

In the past 15 or 20 years the more generally approved way to give adequate care to our acutely ill or hospitalized patient has been the case method. This method assigns to an individual nurse the responsibility for the complete care of a patient or group of patients, including the emotional, spiritual, social and physical needs. In contrast to this system is the functional method which assigns to several nurses varying aspects of the total care of a single patient.

There have been many articles and many arguments set forth for the need to continue with the case method; increasing the supply of nurses by releasing them from industry, private duty nursing and other jobs which are not contributing to the hospital care of our sick. Up to this time there has been no evident improvement or solution to the shortage which continues. The demands on nurses are increasing with extended responsibility, dynamic technology and the future possibilities for any marked increase in available nurses are not very hopeful.

Problems . . There have been many studies made recently, attempting to analyze the situation, comparing the nursing profession with other professions, recognizing the change in the demands on nurses, and watching the changes in the needs of the patients in our hospitals. Some have suggested closing entire hospitals. Many institutions have been obliged to close wards or wings.

This is far from solving our problem when the need for more and more hospital beds is staring us in the face. Partly because people are living longer there is the increased use of hospital insurance and there are more and more ways that the medical profession is finding today to alleviate, correct and prevent illness. Some say we should return to the "efficiency method," "stream-

This paper was read Nov. 7, 1951 before the hospital standardization conference of the American College of Surgeons at San Francisco, Calif.

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line procedures," "shorten courses," "recruit," "use technicians," "use more ward helpers, practical nurses, or nurses aides," and probably there are others.

Some plan must be worked out to fulfill the needs of nursing service. If it is essential that we deviate from our present case method of caring for our patients to a more functional method, can we retain the merits of both systems?

The use of nursing teams or the coordination of the activities of nursing personnel to provide smoothly working units seems to be one possible solution. In recent years there have been an increasing number of studies made to try to determine the function of nursing. What is the difference between nursing care and nursing service? Must all care be done by a professional nurse or can some of the total care be done by technically skilled individuals who are not professionally educated nurses?

There have been time studies, job analyses and experimental research to try to provide answers to these questions. . . Both experiments and experience show that we can and must use non-professional personnel along with the professional nurse and in so doing may even improve the nursing service we are able to give.

Nursing team . . The nursing team would consist of one professional nurse with one or more nurse assistants (nurses aids or ward helpers), and this group would give the direct nursing care to the patients, being responsible both as individuals and a group. In working out a plan for the use of the team, it is presupposed that the members of the team are familiar with the plan, its aims and the responsibilities. The duties of each are clearly defined.

The number of nurse assistants assigned to each professional nurse depends on the type of patient, how acutely ill they are and their location within the unit. It is essential to have the patients realize that the professional nurse is completely aware of the entire group of patients assigned to the team and everything that is being done for them. On the other hand the nurse assistant must be made to feel that she is essential in the total care, and must obtain job satisfaction from her share of the assignment.

Let us take for example a particular unit with an average census of 24 acutely ill surgical women patients. The day staff for this unit consists of one head nurse, one assistant head nurse, three professional nurses, three nurse assistants and one clerk. The general housekeeping and the providing of food is done by other departments. This amount of staff would provide a team for each 12 patients, consisting of a professional nurse and one nurse assistant for each day of the week. (This is figured on the basis of a 40-hour work week.)

The head nurse or her assistant makes the assignment, continuing

continued on page 127

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the hospital pharmacy

How can the hospital get a good pharmacist?

by **Herbert L. Flack** • Chief Pharmacist • Jefferson Medical College Hospital • Philadelphia, Pa.
Lecturer on Hospital Pharmacy • Philadelphia College of Pharmacy and Science

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DIRECTOR OF PHARMACEUTICAL SERVICE: This hospital is desirous of obtaining the services of a competent Chief Pharmacist, position permanent, starting salary dependent upon experience and related qualifications.

■ SUCH REQUESTS are being received by the author with increasing frequency. In the past, it has been difficult to offer recommendations to the administrator who requests assistance in obtaining a chief pharmacist. With the increasing number of graduates of the several educational programs in hospital pharmacy practice, it has become easier to offer such information.

Yet the supply of properly trained personnel to direct the pharmaceutical services in a hospital falls far short of the demand. The reason is that more and more hospital administrators are realizing the need for *specially trained* pharmacists to supervise pharmacy activity in the institution. They are realizing, as is the pharmacy educator, that the problems involved in hospital pharmacy practice are entirely different from the problems of retail pharmacy practice. They realize that the B. Sc. in Pharmacy degree and licensure as a pharmacist is insufficient and that the pharmacist needs additional education and/or experience to qualify for the great responsibility as chief pharmacist in today's hospital.

What type of experience or additional education is available? How can I contact the graduates of such programs? These questions are answered for the hospital administrator in the following paragraphs.

Types of educational or internship programs . . There are several formal programs for pharmacists, requiring either additional education leading to the Master of Science in Pharmacy degree or an internship in an approved hospital pharmacy, or both. There are and will continue to be pharmacists available who have completed such formal training programs as above and also pharmacists who have been employed as "Assistant (Chief) Pharmacist" in a hospital.

The majority of chief pharmacist personnel today have risen through the ranks from the position of assistant in a two-man pharmacy, as assistant chief pharmacist in a larger institution, or as the only pharmacist in a small hospital. This group continues to be an important segment of available material for the hospital administrator who seeks a competent director for his pharmaceutical service.

One word of caution must be presented, however, that the administrator must exert great care in the selection of the individual lest he find that the pharmacist so trained has not been exposed to the modern concepts of hospital practice. The administrator is fairly well assured of a high-type training in modern pharmaceutical practice from the formal internship and educational programs, because the American Society of Hospital Pharmacists has promulgated a "Minimum Standard for Pharmacy Internships in Hospitals" and also a "Syllabus for the Course in Hospital Pharmacy Administration."

There are three types of *formal* programs in hospital pharmacy:

1. The academic internship program.
2. The non-academic internship program.
3. The straight academic program without concurrent internship.

These programs are defined and elaborated upon in the following paragraphs. The hospital administrator may obtain additional information about such programs and may obtain the names of pharmacists completing such programs each year by contacting the individual whose name appears with the listing of the program.

"*A pharmacy internship* in a hospital is a period of organized training in a hospital pharmacy whose facilities and personnel for providing such training have been certified by the Division of Hospital Pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

there's a Pfizer antibiotic for every hospital need

in practical, convenient and economical forms for every hospital service, the following antibiotic agents are now available with the *Pfizer* seal of purity, potency and quality...

TERRAMYCIN

Capsules
250 mg., bottles of 16 and 100
100 mg., bottles of 25 and 100
50 mg., bottles of 25 and 100

Oral Suspension
Vial containing 1.5 Gm.; bottle of 1 fl. oz. special raspberry-flavored, non-alcoholic diluent

Elixir
Vial containing 1.5 Gm.; bottle of 1 fl. oz. flavored, buffered diluent

Oral Drops
Vial containing 2.0 Gm.; bottle of 10 cc. flavored, buffered diluent; calibrated dropper

Intravenous
10 cc. vials containing 250 mg.
20 cc. vials containing 500 mg.

Troches
15 mg. each; boxes of 24

Ointment (topical)
½ and 1 oz. tubes; 30 mg. per Gm.

Ophthalmic Ointment
⅛ oz. tubes; 5 mg. per Gm.

Ophthalmic Solution
5 cc. dropper vials; 25 mg.

Otic Solution (with Benzocaine)
5 cc. dropper vials; 25 mg.

Nasal (with desoxyephedrine HCl)
5 cc. dropper vials; 25 mg.

Soluble Tablets
50 mg. each; boxes of 24

Vaginal Suppositories
100 mg. each; cartons of 10

PENICILLIN

Pronapen* (Penicillin G Procaine Crystalline with Buffered Penicillin G Sodium Crystalline)
Penicillin G Potassium Crystalline
Penicillin G Procaine Crystalline in Oil with 2% Aluminum Monostearate
Penicillin G Procaine Crystalline in Aqueous Suspension
Liquapen*
Penicillin G Procaine Crystalline for Aqueous Injection
Penicillin G Potassium Crystalline Tablets (buffered)
Penicillin G Potassium Crystalline Soluble Tablets
Penicillin G Potassium Crystalline Troches
Pen-Drops*

STREPTOMYCIN

Streptomycin Sulfate

DIHYDROSTREPTOMYCIN

Dihydrostreptomycin Sulfate
Crystalline Dihydrostreptomycin Sulfate Solution

BACITRACIN

Ointment
Ophthalmic Ointment

POLYMYXIN

Sterile (parenteral)
Sterile (topical)
Topical Ointment

COMBIOTIC*

(Penicillin and Dihydrostreptomycin in a *single* injection)
Combiotic* P-S (dry)
Combiotic* Aqueous Suspension

Note to hospital pharmacists: A specially trained group of Pfizer Hospital Service Representatives is now in the field, ready to assist you with information on these antibiotic specialties and offer you other services.

**Trademark, Chas. Pfizer & Co., Inc.*

Pfizer *world's largest producer of antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

****Awarding of certificates of internship . .** upon completion of a typical academic hospital pharmacy internship program in 1951

Two types of internships are recognized: non-academic and academic.

"The *non-academic internship* shall be a period of training of not less than 1,920 hours in a hospital pharmacy. The *academic internship* shall consist of training of not less than 1,920 hours in the hospital pharmacy plus a minimum of one academic year of graduate study in an accredited graduate school associated with a school of pharmacy and leading to the Master of Science degree.

"The applicant for an internship shall be a graduate of a school of pharmacy accredited by the A.C.P.E. The applicant must be of good moral character and in good health. Hospitals offering pharmacy internship programs shall be general hospitals of at least 200 beds and shall have active outpatient pharmacy services. The pharmacy department shall comply with the requirements of the Minimum Standard for Pharmacists in Hospitals. At any one time there shall be no more interns than there are full-time staff pharmacists."*

*Excerpt from the Minimum Standard For Pharmacy Internships In Hospitals, 1951 revision.

**On July 1, 1951, certificates of internship in hospital pharmacy were awarded to three pharmacy interns, bringing the total to six pharmacy interns awarded such certificates for the program in hospital pharmacy which is conducted cooperatively by the Philadelphia College of Pharmacy and Science in Jefferson Medical College and Hospital.

This cooperative program, now beginning its fifth year of operation, is one of the oldest in the country awarding the master of science in pharmacy degree and a certificate of internship.

The picture shows the awarding of certificates of internship in hospital pharmacy. Left to right are Charles Keller, West New York, N.Y.; Joseph Presto, Naugatuck, Conn.; Basil Ketcham, Des Moines, Ia.; Dr. Hayward R. Hamrick, medical director, and Herbert L. Flack, chief pharmacist, both of Jefferson Medical College Hospital, Philadelphia. At the extreme right is Dean Linwood F. Tice of the Philadelphia College of Pharmacy and Science.

CHART A — INSTITUTIONS OFFERING AN ACADEMIC INTERNSHIP IN HOSPITAL PHARMACY

School	Hospital & Program Director	Duration of Course		Number of—		Remuneration
		From-To	Total Time	Interns per Yr.	Graduates Thru 1951	
Columbia University School of Pharmacy	Greenwich Hospital Association Frank J. Steele	Sept. 1952 Feb. 1954	About 18 months	2	0	Tuition $500; $40 per 40 hour week of internship, live in hospital at cost of services.
Direct correspondence to Doctor E. E. Leuallen, at the School, West 66th Street, New York City						
State University of Iowa College of Pharmacy	State U. of Iowa Hospitals Louis C. Zopf	Sept. 1952 June 1954	22 months	2	2	$1200 per year, no maintenance.
Direct correspondence to Louis C. Zopf, above address, Iowa City, Iowa.						
University of Maryland School of Pharmacy	Johns Hopkins Hospital Arthur W. Purdum	Sept. 1, 1952 June 30, 1954	22 months	2	7	$150 per month plus 25% reduction in fee at University.
Direct correspondence to Doctor Edwin L. Crosby, Director, Johns Hopkins Hospital, Baltimore 5, Md.						
University of Michigan School of Pharmacy	University of Michigan Hospital Don E. Francke	Sept. 1, 1952 June 30, 1954	22 months	4	3	$1,400 first year, $1,520 second year. no maintenance.
Direct correspondence to Doctor Don E. Francke, above address, Ann Arbor, Michigan.						
Philadelphia College of Pharmacy and Science	Jefferson Medical College Hospital Herbert L. Flack	Aug. 18, 1952 July 1, 1954	About 22 months	3	6	$800 per 12 month period plus complete maintenance; Tuition about $330 for course.
Direct correspondence to Secretary, Graduate Committee, P.C.P. & S., Philadelphia 4, Pa.						

In accord with recommendation of the Committee on Education of the American Society of Hospital Pharmacists the above institutions are cooperating in an effort to avoid duplication of acceptance for the respective programs, and to provide the opportunity for an applicant accepted by two institutions to select between the two institutions accepting him, rather than accepting the first appointment that is confirmed. Thus it is requested that all applications to be considered be completed by April 1, 1952. Simultaneous announcements of appointments to the respective programs will be made by telegram about May 1, 1952. Alternate choices are to be informed by telegram about May 5, 1952.

YOU CAN STANDARDIZE ON Bi-Pen®

FOR OFFICE AND HOSPITAL USE

Bi-Pen—100,000 units of buffered crystalline penicillin G potassium and 300,000 units of crystalline procaine penicillin G per dose—presents these three features which make it advantageous in the treatment of most penicillin-responsive infections.

EASILY PREPARED

It is prepared for administration (intramuscular only) by simply adding, under antiseptic precautions, the prescribed amount of Water for Injection U.S.P. to the vial. The resultant homogeneous suspension is easily injected.

GOOD BLOOD LEVELS

The soluble crystalline penicillin G potassium of Bi-Pen is promptly absorbed and rapidly leads to high initial plasma levels. Its procaine penicillin is absorbed more slowly, maintaining levels of more than adequate magnitude for therapeutic efficacy. A single dose of Bi-Pen produces these levels for 24 hours in most patients.

Bi-Pen is supplied in three package sizes for utmost flexibility in use: (1) five dose vials; (2) single dose vials in individual boxes; (3) single dose vials in boxes of 50.

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A DIVISION OF COMMERCIAL SOLVENTS CORP., 17 E. 42ND ST., NEW YORK 17, N. Y.

C. S. C. PENICILLIN PREPARATIONS

Compenamine — Crystalline Penicillin G Potassium
Compenamine Aqueous — Crystalline Procaine Penicillin G in Oil
Compenamine in Oil — with 2% Aluminum Monostearate

Bi-Pen® Soltabs®
Tablets Buffered Crystalline Penicillin G Potassium

CHART B — INSTITUTIONS OFFERING A MASTER OF SCIENCE DEGREE WITH NO INTERNSHIP

School	Duration of Course	Number of Graduates Thru 1951	Remuneration
State University of Iowa College of Pharmacy	One academic year	4	———
Direct correspondence to Louis C. Zopf, at the above school, Iowa City, Iowa.			
Purdue University School of Pharmacy	Two academic years with Teaching Assistantships	9	Teaching Assistantships, $1500 to $1800 per year, plus remittance of all fees except $30 per semester.
Direct correspondence to Doctor Glenn L. Jenkins, at the above school, West Lafayette, Indiana.			
University of Wisconsin School of Pharmacy	Two academic years	0	Teaching Assistantships at approximately $90 per month.
Direct correspondence to Doctor Louis Busse, at the above school, Madison, Wisconsin.			

Academic internship programs . . In these programs the usual duration of time is 22 months during which period there is lecture and laboratory instruction at the cooperating college of pharmacy taken concurrently with internship instruction at the hospital. Graduate level courses usually include hospital pharmacy administration and seminar, pharmacology, biochemistry, manufacturing problems, research and others. The student usually lives at the hospital in quarters with the resident medical staff and is subject to the same regulations as apply to the interns. He is usually required to schedule his off-duty hours so that one intern pharmacist will be on call to provide emergency pharmaceutical service. The average work week for full-time internship is 40 hours, plus the emergency service responsibility. He receives a stipend of varying amount from the hospital which is usually sufficient to meet all living expenses plus tuition fees.

The student is encouraged to attend the staff meetings in the hospital and pertinent meetings of related organizations in the community as well as the annual Hospital Pharmacy Institute and annual convention of his professional organization. He is usually required to assist in the teaching of pharmacology and related subjects to the student nurses at the hospital. The academic instruction and internship combined is designed to provide complete and well-rounded experience in the functioning of today's hospital. Upon completion, the graduate should be thoroughly familiar with hospital organization and with the relation of pharmacy to the medical staff and to other departments of the hospital. He should be highly qualified to serve as director of pharmacy service in a hospital.

Five institutions offer the academic internship program with a maximum enrollment of 13 students each year. There have been 18 pharmacists complete these courses through 1951, with nine additional expected to graduate in 1952, and 11 additional graduating in 1953.

Chart A, which is on page 110, lists the available academic internship programs together with pertinent vital statistics.

CHART C — INSTITUTIONS OFFERING A NON-ACADEMIC INTERNSHIP (formal program)

Institution	Number of Graduates Through 1951	Number Accommodated Per Year	Remuneration
Duke University Hospital Durham, N.C. I. T. Reamer	20	2	$2,040 per year plus maintenance
Freedmen's Hospital Washington, D.C. John S. Mitchell	2	2	$100 per month
Greenwich Hospital Assoc. Greenwich, Conn. Frank J. Steele	0	1	$40 per week
Mercy Hospital Toledo, Ohio Sister Mary John	8	2	$225 per month, time allowed for college work if desired.
Queen of Angels Hospital Los Angeles, California Sister Mary Junilla	6	2	$140 per month for 40 hour week
Saginaw General Hospital Saginaw, Michigan Miss Jennie Banning	0	1	Open
St. Clare's Hospital New York 19, New York Sister Mary Donatus	0	1	$125 per month
St. Luke's Hospital Cleveland 4, Ohio Mrs. Evlyn G. Scott	11	4	$50 per month, **complete** maintenance, hospitalization insurance, entrance dates are July, Sept., Oct. & Jan.
St. Mary's Hospital 1298 St. Mark's Ave. Brooklyn, New York Sister Mary Etheldreda	3	1	$150 per month, 1 meal daily, laundering of uniforms.
University of Calif. Hosp. San Francisco, California Jerome M. Yalon	12	3	———

ONE KILLS SAFELY

An antiseptic with a "blunderbuss" effect . . . further damaging already tender, traumatized skin or mucosa . . . is as primitive as the searing iron.

Zephiran chloride is free from antiseptic crudity. It is a refined bacteri*cidal* agent; pharmacological tests for tissue tolerance are made on each lot.

Supplied as:
Aqueous Solution 1:1000, bottles of 8 oz. and 1 U. S. gallon.

Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U. S. gallon.

Concentrated Aqueous Solution 12.8%, bottles of 4 oz. and 1 U. S. gallon (1 oz.=1 U. S. gallon 1:1000 solution).

Winthrop-Stearns Inc.

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ZEPHIRAN®

CHLORIDE

for antisepsis with finesse . . .

Zephiran, trademark reg. U. S. & Canada, brand of benzalkonium chloride refined

Graduate degree programs without internship . . These programs are aimed at providing graduate study leading to the Master of Science degree for those persons who have worked in a hospital pharmacy and who want to further qualify themselves for the responsibility of chief pharmacist in a large hospital. They might also be taken by an individual who wants the graduate degree and then plans to work in a hospital pharmacy or serve an internship in one of the formal programs as a means of qualifying for the chief pharmacist position. Special courses in hospital pharmacy administration, manufacturing, pharmacology, etc., emphasize the hospital picture.

There have been 13 graduates of such programs through 1951, with only two schools offering such programs. It is expected that 5 additional persons will complete these programs in 1952. Chart B lists the available programs leading to the degree only, with pertinent data.

Non-academic internship programs . . The non-academic internship programs have been in existence the longest of any of the formal education programs and consequently have the most graduates. There are 10 such *formal* internship programs which have produced 62 graduates through 1951. Unfortunately there are only nine graduates expected in 1952 though the existing programs will accommodate 20 pharmacists per year.

The non-academic internship usually involves 52 weeks of 40 hours, with an honorarium being paid at approximately one-half to two-thirds the usual rate for pharmacist personnel. In this program, as in the internship phase of the academic program, the intern (student) serves a rotating internship in the several (usually five) divisions of the hospital pharmacy. He attends staff conferences and other activities as listed under the academic program. Chart C lists the existing non-academic internship programs together with other data. Hospital administrators interested in graduates of the several programs should contact the individual listed with the program, who is chief pharmacist at the institution named.

Conclusion . . The remarkable developments in the past few years in the hospital picture have made it necessary for pharmacy to develop specially trained personnel to meet the demands of the minimum standard for pharmacies in hospitals. Hospital administrators now recognize the value of, cost of, and benefits derived from a complete, self-sufficient pharmacy service. They realize that professional schooling and practical experience in a retail pharmacy do not provide sufficient background for a hospital pharmacist.

A review of the existing educational facilities to provide the necessary specialists in hospital pharmacy has been presented for benefit of both hospital administrator and graduate or student pharmacist. The names of the several hospitals and schools together with names of directors of the programs are included so that the hospital administrator who needs a competent pharmacist and the pharmacist who desires the enjoyable opportunities presented by hospital practice, can contact the individuals with their problems. ■

Early tests look promising for tuberculosis treatment

■ WIDESPREAD NEWSPAPER PUBLICITY, originating in New York around Feb. 21, told of sensational results in tests of a new drug at the city's Sea View Hospital for tuberculosis on Staten Island. According to the verified stories in the press, experiments on a group of 92 advanced cases of tuberculosis, many of them regarded as hopeless, had within three weeks reduced temperatures to normal, restored appetite and energy and apparently killed the t.b. germ.

Dr. Marcus D. Kogel, the city commissioner of hospitals, was quoted as declaring that the new drug had stopped tuberculosis "dead in its tracks," adding that if the treatment continues to give results which prove to be permanent the construction of the new tuberculosis hospitals planned by the city may be unnecessary.

The tests at Sea View were verified by Dr. Edward H. Robitzek, acting director of the hospital's department of medicine, and Dr. Irving J. Selikoff, a member of the visiting staff. The results of the tests on the Sea View group were not to have been published until April 1, but the news was given out earlier and spread rapidly because of its dramatic character.

One result of this was some embarrassment to two leading pharmaceutical manufacturers, E. R. Squibb & Sons, New York, and Hoffmann-LaRoche, Inc., of Nutley, N.J., who after long research had developed identical drugs at just about the same time. The Squibb product is to be known as Nydrazid, while the Hoffmann-LaRoche experiments produced two different forms to be known respectively as Rimafon Roche and Marsilid Roche.

Feeling that the clinical evidence so far accumulated, while dramatic and encouraging, was still incomplete, since it cannot yet be said that the disease has been permanently arrested in any of the cases, both companies were somewhat upset at the unplanned publicity, which immediately brought them nation-wide inquiries.

The Squibb company felt it necessary to apologize to the medical profession and sent letters to this effect to 135,000 practicing physicians, explaining that "the premature announcement of Nydrazid to the public" was not its idea and that the stories found their way "into the lay press before the completion of clinical studies" under circumstances beyond the company's control. Full details, it was promised, will be available in April.

Hoffmann-LaRoche, after thinking the matter over, issued a release explaining the development of the new drugs, adding that "These drugs appear to be more effective in the treatment of tuberculosis than any other substance known at present."

A reminder was given that Dr. H. Herbert Fox, who has had a great deal to do with the research in-

continued on page 155

Slow Rising Roy is a quick coffee boy

Each DAYALET Tablet Contains:

Vitamin A	10,000 U.S.P. units (synthetic vitamin A palmitate)
Vitamin D	1000 U.S.P. units (Viosterol)
Thiamine Mononitrate	5 mg.
Riboflavin	5 mg.
Nicotinamide	25 mg.
Pyridoxine Hydrochloride	1.5 mg.
Vitamin B_{12}	1 mcg. (as vitamin B_{12} concentrate)
Pantothenic Acid	5 mg. (as calcium pantothenate)
Ascorbic Acid	100 mg.

NO FISH-OIL TASTE OR BURP

BOLT his breakfast and gulp his lunch, gobble down dinner and Roy is another day nearer a subclinical vitamin deficiency. In treating vitamin deficients, many physicians bolster new dietary habits with one or two DAYALETS each day.

DAYALETS are fishless, burpless tablets containing *synthetic* vitamin A . . . plus B_{12} . . . plus seven other important vitamins. No fish-oil odor, taste or aftertaste, no allergies due to fish oil. DAYALETS can't leak, won't stick together in the bottle. Supplied in bottles of 50, 100 and 250. Abbott

Dayalets®

(Abbott's Multiple Vitamins)

hm

food and dietetics

Under the editorial direction of J. Marie Melgaard, chief dietitian, Chicago State Tuberculosis Sanitarium, Chicago, Illinois

How St. Luke's of Denver made a 180-patient kitchen serve a 450-patient load

by **Roy R. Prangley** • Administrator • St. Luke's Hospital • Denver
and **Josephine K. Faunce** • Director • Dietary Department

■ LIKE MOST HOSPITALS these days, St. Luke's Hospital in Denver has been fighting the continuous battle of increased operating costs versus better service to our patients. Like many others we have also had the acrobatic task of balancing budgets for essential expansion from 280 to 450 beds.

With dietary accounting for a big bite out of every operating dollar and looming as a very expensive factor in the over-all economy of our expansion program, we turned concentrated effort to this vital department early in our planning stages. Moreover, our building funds did not allow for any expenditures that could be avoided by taking fullest advantage of existing buildings and facilities.

The questions . . Lengthy studies soon resolved into finding the most satisfactory answers to the following questions:

1. Could we possibly meet food storage, preparation, and cooking requirements for the 450-bed unit in our existing kitchen (originally planned for only 180 beds)?

2. Could we add badly needed space on nursing floors in the old buildings and make most productive use of costly floor space in the new building?

3. Could we minimize structural and equipment costs in the new building?

4. Could we find space immediately for a coffee shop to take over meal service for odd-hour personnel, visitors and ambulant patients? And would this coffee shop be financially self-supporting?

5. Could we improve food services to all without adding to existing dietary serving costs per bed?

6. Simultaneously, could we eliminate food service complaints from patients, particularly the perennial comment that hot foods were cold?

The answers . . The system we have devised has provided an unqualified "yes" to all of the above critical questions.

It was self-evident that basement floor space is at a lesser premium than space on nursing and administrative floors above. So, the route to our objectives logically led toward centralization of all food services from a single main kitchen to release the space consumed by five serving kitchens on the upper floors.

We have always been told that central service encouraged more complaints about "cold food." However, the several steps we have taken completely by-pass this misconception. How we realized the foregoing important objectives may be summarized as follows:

Figure 1 shows our main kitchen for former decentralized service and before any centralization.

Figure 2 shows the main kitchen as converted for central service to 280 beds.

Figure 3 shows our final main kitchen modifications for central service to the new total of 450 beds.

Of particular interest is the fact that our cooking area has remained constant in our 35% expansion. Whereas it was formerly necessary to cook all foods in bulk for simultaneous distribution to five serving pantries, they are now freshly cooked in small quantities throughout the central tray preparation period.

Figures 4 through 6 show progressively how the entree courses for each patient are now individually vacuum-sealed in insulated stainless steel containers along a motorized-belt table. After packing and sealing, Figure 6 shows how each container goes on each patient's tray which is then completely assembled on the moving belt under the personal supervision of the qualified dietary staff. We offer a selective menu to 35 per cent of the patients not on a restrictive diet.

continued on page 120

From Every Point of View

More Coffee Flavor is important!

There are many tastes to please in a hospital—nurses, patients, doctors, the administrative staff. In coffee *all* want *FLAVOR*. Millions enjoy Continental Coffee because it has the *most* in flavor—delicious, winey-rich, full-bodied and unvaryingly fine—kept so by special Automatic Roasting Controls that maintain exact uniformity.

These qualities of more flavor and uniformity, plus Continental's topnotch coffee service, all add up to *value*—value so highly regarded that nearly 20,000 hospitals, restaurants, hotels, and other dining places prefer and serve Continental Coffee today!

For more coffee flavor in your hospital, for more coffee enjoyment and *better value*, see your Continental Man...now!

For best results regardless of brand—always brew your coffee 2½ gallons to the pound.

Continental Coffee

AMERICA'S LEADING COFFEE for RESTAURANTS, HOTELS AND INSTITUTIONS

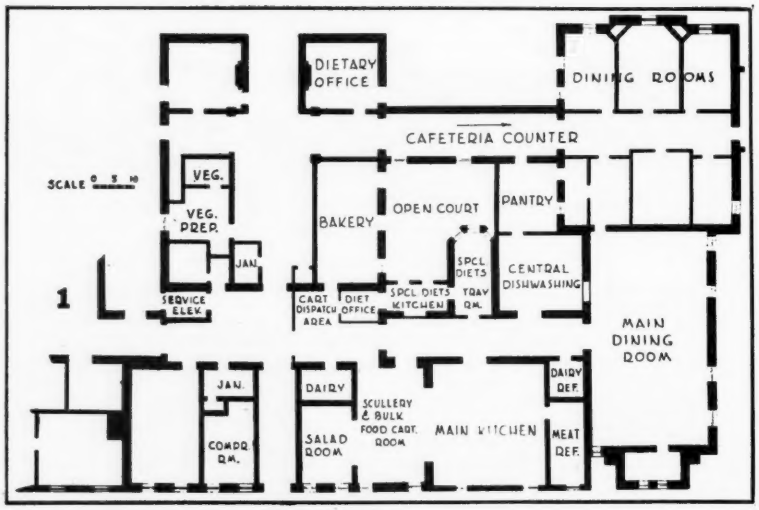
CONTINENTAL COFFEE COMPANY CHICAGO • BROOKLYN • TOLEDO

Importers Roasters • Members New York Coffee and Sugar Exchange

MAKERS OF CONTINENTALS FAMOUS "76" MENU PRODUCTS

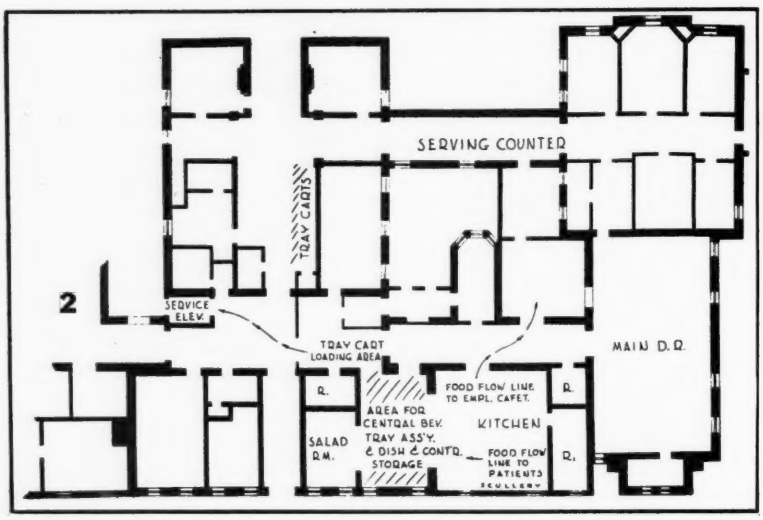
Before . .

FIGURE 1 . . Original dietary department floor plan at St. Luke's Hospital, Denver, when there was decentralized floor pantry service for 285 beds



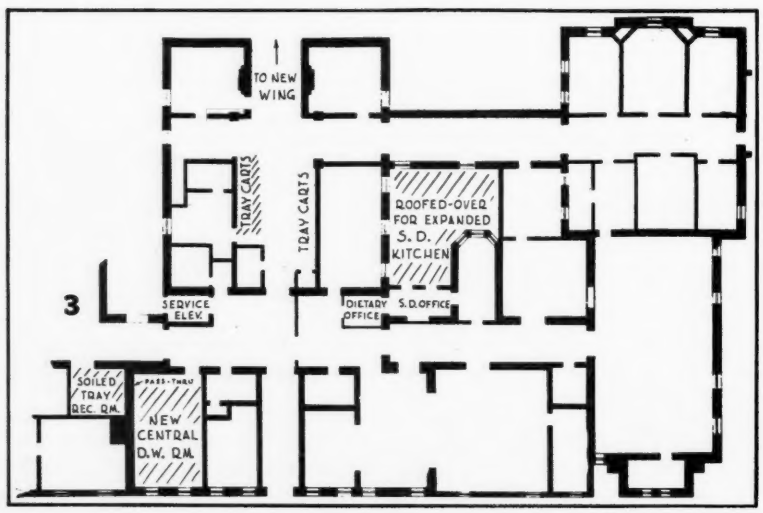
. . during . .

FIGURE 2 . . After initial conversion to Mealpack central food service for 285 beds, eliminating five floor pantries. The shading indicates converted areas



. . after

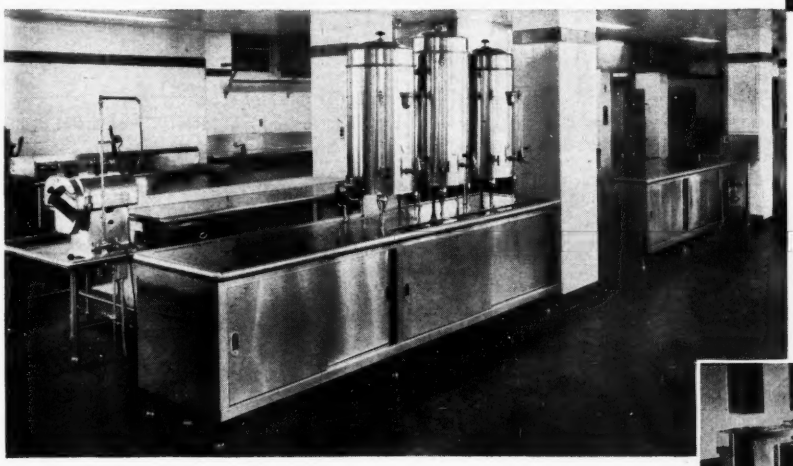
FIGURE 3 . . Floor plan of dietary department after expansion of Mealpack central service to 450 beds, eliminating need for three additional floor pantries. Shading shows expansion areas



"25% more people served... 10% reduction in kitchen help"

FIRST-YEAR RECORD OF WILSON MEMORIAL HOSPITAL'S BLICKMAN-BUILT FOOD SERVICE INSTALLATION

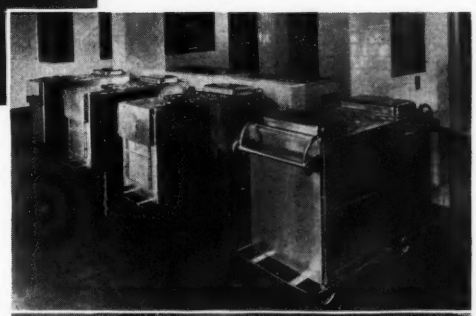
MR. ROBERT L. ECKELBERGER
Adminstrator, Wilson Memorial Hospital

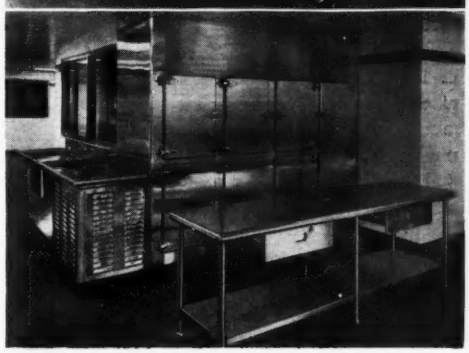


Left: **Main kitchen, showing stainless steel coffee urns and stand in foreground, stainless steel vegetable preparation and cooks' tables in background.**

Below: **Group of electrically-heated stainless steel food conveyors with seamless top and body construction. Hot foods are transported in bulk from main kitchen to individual serving pantries.**

Bottom: **Salad preparation area, showing stainless steel sink, refrigerator and work table with round-corner drawers.**





• After one year of operation, the new Blickman-Built food service installation at 500-bed Wilson Memorial Hospital, Johnson City, New York, has achieved a marked improvement in service — at a considerable saving in time and labor.

Mr. Robert L. Eckelberger, administrator, states:
"Our old kitchen was very poorly arranged, space was insufficient. Now we are serving 25% more people, with a reduction in kitchen help of approximately 10%. Needless to say, the layout and the fine type of equipment are almost entirely responsible for this marked saving."

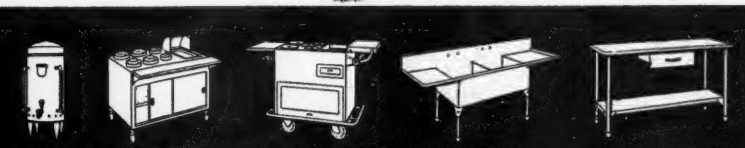
Careful planning and fine fabrication are the main reasons for this over-all operating efficiency. All sections of the kitchen were planned for smooth, step-saving work-flow. Individual units were designed to effect a high degree of sanitation with a minimum of labor.

Follow the example of this leading institution, an award-winner in the 1951 Institutions Food Service Contest. Specify a Blickman-Built kitchen for cost-cutting benefits in your own mass-feeding installation.

Send for illustrated folder
describing Blickman-Built food service equipment, available in single units or complete installations.

S. Blickman, Inc., 1603 Gregory Ave., Weehawken, N.J.

Blickman-Built
FOOD SERVICE EQUIPMENT
EST. 1886



You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 24-26 and to the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., April 16-18.

continued from page 116

As each tray is completed (see Figure 7), it is inspected for accuracy and uniform neatness. It is then loaded into an enclosed stainless steel tray cart (see Figure 8) which has a capacity of 20 trays. Ten of these carts will serve the complete hospital as each cart may make return trips to handle from 40 to 60 trays during each serving period.

Floor pantry . . Each of these unique tray carts is literally a "floor pantry on wheels," and includes insulated bulk dispensers for serving such foods as chilled juice, hot coffee, soup, hot water (for tea and bouillon) and ice cream. These perishable and "spillable" foods are added to each tray by a cart girl at the point of service immediately before trays are given to patients, thereby assuring proper serving temperatures and textures.

Because St. Luke's operates a nurse's training school, special diets are handled in a similar manner from a separate training kitchen. Students, under the direction of a dietitian, conduct all operations, from writing special diets through preparation and final service to patients.

Surveys of patient reaction to this new service show practically unanimous approval because both hot and chilled foods are now served in ideal, savory condition . . even when some trays are delayed as much as an hour due to patients' unavoidable absences from rooms and other interruptions at regular serving time.

Other uses . . This centralization has already released five floor kitchens in the old buildings for more productive uses. These areas could have been converted into five additional private rooms to provide $4,420 in extra revenue per year per room (sufficient to repay our change-over costs within a year!).

However, the additional capacity of our new building permitted us to provide several long-needed new floor facilities from four of the five old pantries. Accordingly, both the old and new buildings will enjoy the benefits of facilities made possible entirely by space released in our change-over from decentralized to centralized tray service as follows:

1. An enlarged coffee shop providing 24-hour service for visitors and hospital personnel.

2. An improved and enlarged barber shop, relocated where it will invite more revenue through increased volume.

3. Extra storage and work space pertaining to patient care on patient landings.

Efficiency . . We anticipate that when we open our new 180-bed addition this spring we will have a net gain of 170 beds since we will lose about 10 beds in the present hospital in the five floor connections. Our total capacity will then be 450 beds instead of the present 280 beds. However, instead of operating at our present 100% capacity, we expect to operate at not more than 85% occupancy and plan on serving

continued on page 124

FIGURE 4 . . Start of tray assembly at Mealpack motorized belt table. Pyrex insert dishes are pre-heated in infra-red dish heater by kitchen porter at left

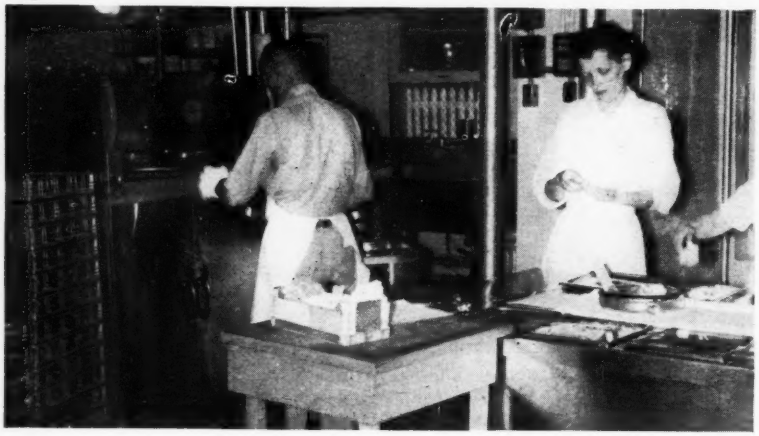
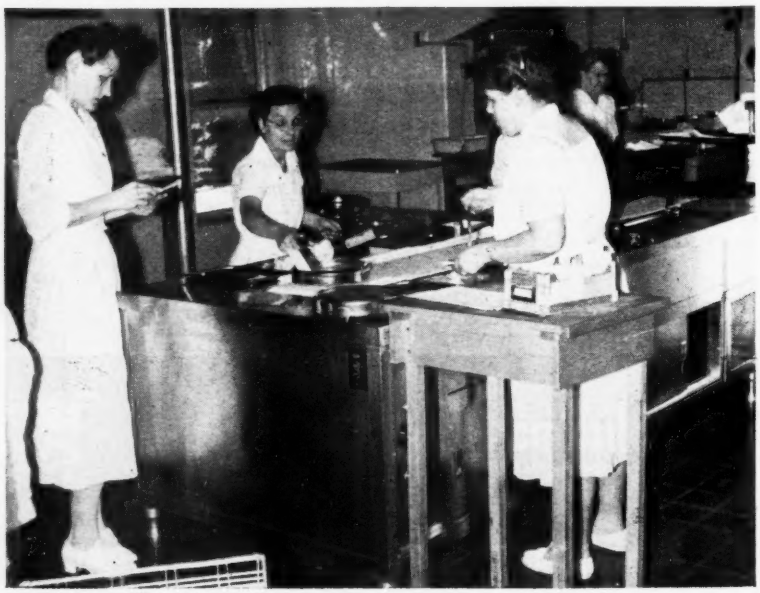


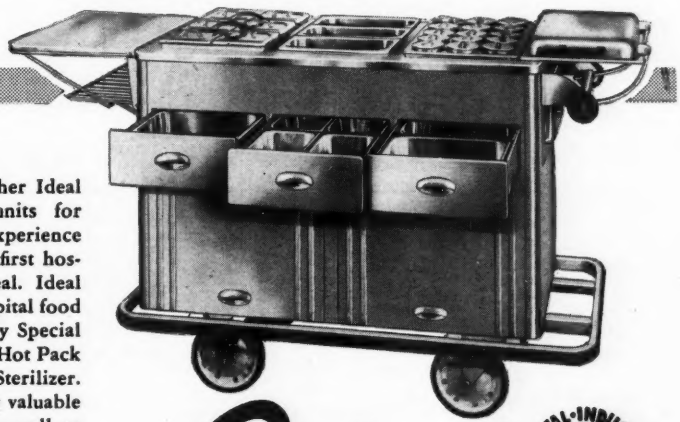
FIGURE 5 . . Pre-heated Pyrex dish in bottom half of Mealpack container starts along slowly moving belt. Dietitian at left calls out each patient's menu in volume of food requested. Two food handlers in front apportion general diet meats and vegetables for entire hospital



HOW HEAT OF ONE FLATIRON WILL KEEP 60 MEALS HOT AND APPETIZING!

Electricity is among the critical things soon to be in short supply. National defense and your own budget both bespeak conservation of this convenient form of energy so necessary to hospital operation.

Ideal engineering makes a little electric power do a big job in a food conveyor. An average electric flatiron consumes 1000 watts per hour. The maximum required by an Ideal Food Conveyor is 961 watts per hour, which keeps 60 meals or special diets hot, fresh and at their nutritional best.



Ideal Food Conveyors and other Ideal thermostatically controlled units for hospital use embody a vast experience in this specialized field. The first hospital food conveyor was an Ideal. Ideal developed the first electric hospital food conveyor. Ideal builds the only Special Diet Tray, the only Automatic Hot Pack Heater and the only Terminal Sterilizer. Ideal equipment delivers many valuable new therapeutic advantages as well as saving money, labor and time in routine hospital operation.

Ideal

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Made only by the **SWARTZBAUGH MFG. COMPANY** *Established in 1884 - Toledo 6, Ohio*

FOOD CONVEYORS • TRAY CONVEYORS • HOT PACK HEATERS

Distributed by the Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Company, Los Angeles, and San Francisco. In Canada: Canadian Fairbanks-Morse Company.

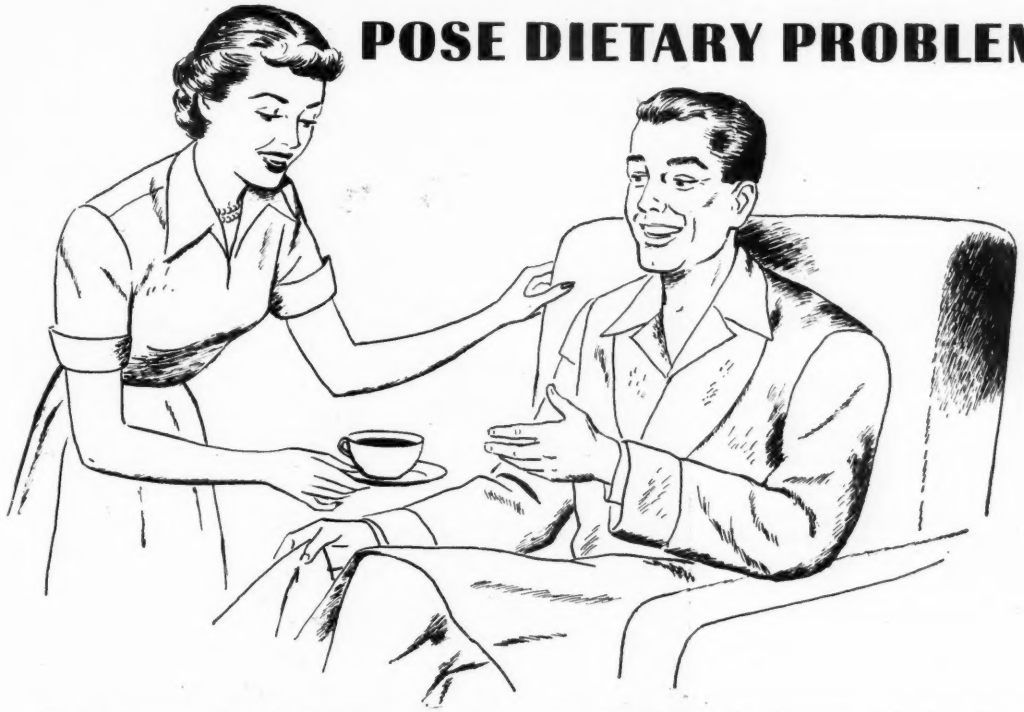
monthly menus (hm) . . . April

Suitable for staff, personnel and patients not requiring special diets

	Breakfast	Dinner	Supper
Tues. 1.	Blue Plums; Hot Cereal; Parsley Scrambled Eggs; Toast	Spanish Meat Balls; Sweet Potato Puff; Bu. Broccoli; Tropical Salad; Cabinet Pudding	Tomato-Okra Soup; Canadian Bacon; Creamed Potatoes & Peas; Shredded Lettuce; Peach Foam Tart
Wed. 2.	Orange Segments, Hot Cereal; French Toast — Jam	Danish Pork Chop; Mashed Potatoes; Escalloped Cabbage; Carrot-Raisin Salad; Apple Torte a la Mode	Cheese-Noodle Soup; Corned Beef Hash with Poached Egg; Spring Salad; Lemon Snow
Thurs. 3.	Grapefruit Juice; Hot Cereal; Crisp Bacon; Cherry Kolaci	Roast Prime Ribs of Beef — Yorkshire Pudding; Stuffed Baked Potato; Bu. Wax Beans; Pickled Beet Salad; Fruit Compote	Bouillon; Veal Croquettes—Tomato Sauce; Steamed Rice; Mexican Salad; Graham Cracker Pudding
Fri. 4.	Bananas-Cream; Cold Cereal; Shirred Egg; Raisin Toast	Fillet of Pike; New Potatoes in Jackets; Breaded Tomatoes; Fruit Aspic Salad; Lemon Cheese Cake	Jungle Soup; Crabmeat, Mornay; Shoestring Potatoes; Spiced Peach Salad; Frosted Fruit Cocktail
Sat. 5.	Apple Sauce; Hot Cereal; Omlet; Toast	Vienna Roast; Lyonnaise Potatoes; Spinach a la Swiss; Lettuce Wedge — Roquefort-Egg Dr.; Apricot Whip	Washington Chowder; Steak & Kidney Pie; Succotash; Crisped Relishes; Marble Cake
Sun. 6.	Grapefruit Half; Hot Cereal; Sausage Links; Pecan Coffee Cake	Veal Birds; Mashed Potatoes; Frozen Peas; Corn Relish Salad; Chocolate Mousse	Hot Turkey Biscuit Sandwich, Potato Flakes; Tomato-Cress Salad; Candied Fruit Bars; Spiced Punch
Mon. 7.	Kadota Figs; Cold Cereal; French Pancakes —Preserves	Brunswick Stew; Paprika Cauliflower; Hot Buttered Bread Sticks; Tossed Green Salad; Baked Molasses Pears	Creole Soup; Veal Paprika; Potato Puff; Molded Fruit Salad; Fudge Frosted Brownies
Tues. 8.	Tomato Juice; Hot Cereal; 3-Minute Egg; Toast	Yearling Liver with Tiny Onions; Escalloped Potatoes; Green Beans; Normandy Salad; Cranberry Upside-Down Cake	Potato Chowder; Pigs-in-Blankets-Buns; Imperial Salad; Pickles; Fruited Caramel Eclair
Wed. 9.	Stewed Peaches; Hot Cereal; Bacon Curls; Sweet Rolls	Roast Shoulder of Veal—Mushroom Stuffing; Hash Brown Potatoes; Creole Celery; Banana-Cherry Salad; Lime Gelatine Cubes—Custard Sauce	Vegetable Soup; Braised Sirloin Tips; Sauted Potatoes; Assorted Relishes; Blueberry Pinwheel—Lemon Sauce
Thurs. 10.	Grape Nectar; Hot Cereal; Scrambled Eggs; Cinnamon Toast	Minted Lamb Fillet; Chantilly Potatoes; Acorn Squash; Lettuce—1000 Is. Dr.; Caramel Tapioca	Spanish Bean Soup; Ham Loaf; Baked Sweet Potato; Apple-Cabbage Slaw; Sponge Cake a la Mode
Fri. 11.	Rhubarb Sauce; Hot Cereal; Baked Egg in Cream; Hot Cross Buns —Jelly	Fr. Fr. Louisiana Prawns; Rhode Island Potatoes; Fresh Spinach Mounds; Golden Glow Salad; Cottage Pudding—Cherry Sauce	Tomato Consomme; Stuffed Peppers with Tuna and Corn; Cottage Potatoes; Marinated Cucumbers; Refrigerator Cheese Cake
Sat. 12.	Prunicot; Hot Cereal; Poached Egg; Raisin Toast	German Pot Roast; Oven Browned Potatoes; Beet Greens with Egg; Pickle Relish Salad; Vanilla Blanc Mange	Pepper Pot; Lemoned Pork Chop; Duchess Potatoes; Waldorf Salad; Fruit Bars
Easter Sun. 13.	Frozen Strawberries; Cold Cereal; Grilled Ham & Eggs; Danish Coffee Ring	Fried Spring Chicken—Cream Gravy; Riced Potatoes; Fresh Asparagus Spears; Jellied Cranberry Salad; Pistachio Ice Cream; Easter Cookies	Oxtail Soup; Assorted Finger Sandwiches; Fruit Salad Plate; Crispy Relishes; Chocolate Chip Spanish Cream
Mon. 14.	Sliced Oranges; Hot Cereal; 3-Minute Egg; Toast	Browned Short Ribs of Beef; Maitre d'Hotel Potatoes; Paprika Cauliflower; Shredded Lettuce; Chilled Fruit Cup	Vegetable Soup; Crisp Bacon; Noodle Nest—Cheese Sauce; Fiesta Salad; Boston Cream Pie
Tues. 15.	Pineapple Juice; Hot Cereal; French Toast—Syrup	Roast Leg of Lamb with Capers; Mashed Potatoes; Escalloped Egg Plant; Sunburst Salad; Bread Pudding, DeLuxe	Consomme; Veal Turnover—Vegetable Sauce; Tomato Petal Salad; Iced Gingerbread Cup Cake
Wed. 16.	Apple Sauce; Hot Cereal; Omelet; Toast	Boiled Beef—Horseradish Sauce; New Potatoes; Bu. Carrots & Peas; Leaf Lettuce—Sour Cr. Dr.; Fruit au Gratin	Tomato Soup; Curry of Chicken; Fluffy Rice; Garden Salad; Date Nut Bars
Thurs. 17.	Grapefruit Sections; Hot Cereal; Scrapple; Cinnamon Twists	Mock Chicken Legs; O'Brien Potatoes; Pimiento Wax Beans; Chutney Relish; English Toffee Ice Cream	Beef Bouillon; Hungarian Goulash with Dumplings; Cole Slaw; Strawberry Tart Basket
Fri. 18.	Blue Plums; Hot Cereal; Poached Egg; Toast	Mackerel, Spanish Style; Bu. Crumb Potatoes; Bu. Zucchini; Wilted Spinach Salad; Cake Top Lime Pudding	Mushroom-Oyster Soup; Tomato-Bacon-Cheese Rarebit; Latticed Potatoes; Pineapple-Date Salad; Fruit Jumbles
Sat. 19.	Blended Fruit Juice; Hot Cereal; Scrambled Eggs; Toast	Roast Fresh Ham; Whipped Potatoes; Brussels Sprouts; Spiced Apple Ring Salad; Rhubarb Betty	Bortsch; Broiled Lamb Pattie; Creamed Potatoes with Chives; Salad Macedoine; Apricot Cobbler
Sun. 20.	Fresh Pineapple Wedges; Hot Cereal; Bacon Curls; Toasted English Muffins —Jelly	Roast Tenderloin of Beef—Mushrooms; Fr. Fr. Potatoes; Corn a la Southern; Sweet Relish—Radishes; Sugar Wafer Ice Cream Sundae	Two-Tone Cocktail; Turkey a la King in Patty Shell; Bu. Peas; Frozen Fruit Salad; Iced Graham Crackers
Mon. 21.	Orange Juice; Hot Cereal; Shirred Egg; Toast	Scallopini of Veal; Parslied Bu. Potatoes; Fresh Spinach; Chinese Cabbage Salad; Delicia Cake	Potato Chowder; Frizzled Beef with Hot Buttermilk Biscuits; Green Bean & Celery Salad; Pineapple Surprise
Tues. 22.	Bananas—Cream; Cold Cereal; Link Sausage; Swedish Rolls	Smothered Steak; Roast Potato Balls; Harvard Beets; Vegetable Jackstraws; Maple Custard	Vegetable Soup; Hot Spiced Tongue—Mustard Sauce; Stuffed Baked Potato; Pear-Grated Cheese Salad; Butterscotch Roll
Wed. 23.	Baked Apple; Hot Cereal; 3-Minute Egg; Raisin Toast	Chicken—Ham Shortcake; Sweet Potato Scones; Fresh Asparagus; A-B-C- Salad; Cherry Ice Cream	Lentil Soup; Manhattan Meat Roll; Tomato-Endive Salad; Vienna Tart
Thurs. 24.	Grapefruit Half; Hot Cereal; Omelet; Toast—Jelly	Crown Roast of Lamb; Chantilly Potatoes; Frozen Broccoli; Lettuce Wedge—Russ. Dr.; Prune Whip	Potato-Carrot Soup; Cold Roast Beef; Macaroni au Gratin; Beet-Egg Salad; Fruited Gelatine Pie—Wh. Cr.
Fri. 25.	Tomato Juice; Hot Cereal; Scrambled Eggs; Toast	Baked Shad—Lemon Slice; Potatoes Rissole; Braised Celery; Fruit Salad; Glorified Rice Pudding	Split Pea Soup; Seafood Casserole; Julienne Potatoes; Adirondack Salad; Orange Chiffon Cake
Sat. 26.	Baked Rhubarb; Hot Cereal; Scrapple; Muffins—Honey	Salisbury Steak; Franconia Potatoes; Browned Creamed Carrots; Tossed Green & White Salad; Fruited Floating Island	Alphabet Soup; Baked Stuffed Pork Tenderloin; Mashed Potatoes; Stuffed Celery Salad; Snow-Top Apple
Sun. 27.	Sliced Oranges; Hot Cereal; Crisp Bacon; Coffee Cake	Chicken, Hawaiian; Savory Fried Noodles; Bu. Squash; Heart of Palm Salad; Neapolitan Ice Cream	Consomme; Barbecued Beef; Baby Green Lima Beans; Peach Bloom Salad; Frosted Doughnuts
Mon. 28.	Kadota Figs; Hot Cereal; Baked Egg; Toast	Breaded Veal Chop; Whipped Potatoes; Bu. Wax Beans; Tomato Aspic Salad; Ice Box Pudding	Mushroom-Bisque; Hamburger-Potato Pie; Spring Garden Salad; Lazy Daisy Cake
Tues. 29.	Grapefruit Juice; Hot Cereal; 3-Minute Egg; Toast	Lamb Stew with Vegetables; Hominy Cakes; Cornbread Sticks; Wilted Lettuce; Chilled Fruit Cup	Okra Soup; Scalloped Potatoes with Ham; Combination Vegetable Salad; Rolled Apple Dumpling
Wed. 30.	Bananas—Cream; Cold Cereal; Sausage Squares; Brioche	Beef a la Mode; Browned Potatoes; Minted Carrots; Piquant Egg Salad; Strawberry Shortcake—Wh. Cr.	Cream of Vegetable Soup; Grilled Bologna; Spanish Rice; Chiffonade Salad; Melba Peach

When Functional Derangements

POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among such functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk, provide:

PROTEIN	32 Gm.	VITAMIN A	3200 I.U.
CARBOHYDRATE	65 Gm.	VITAMIN D	420 I.U.
FAT	30 Gm.	ASCORBIC ACID	30 mg.
CALCIUM	1.12 Gm.	NIACIN	6.7 mg.
COPPER	0.7 mg.	PANTOTHENIC ACID	3.1 mg.
IODINE	0.7 mg.	PYRIDOXINE	0.6 mg.
IRON	12 mg.	RIBOFLAVIN	2.0 mg.
PHOSPHORUS	940 mg.	THIAMINE	1.2 mg.
CALORIES	658		

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

continued from page 120

food to about 380 patients for a net gain of about 100 patients.

Our new individual stainless steel insulated container service has made most of these improvements possible. Had it been necessary to install a new kitchen to meet the 30 per cent increase in capacity as originally planned for decentralized service, our available funds would not have permitted construction to the capacity now well under way.

In addition we now serve a better variety of enticing hot foods to all patients with an efficient centralized system in the maximum time of 45 minutes to one hour. We have been able to eliminate most of the former split shifts of dietary employes which greatly limited the area from which we could enlist personnel. Instead of five crews serving trays partially supervised by dietitians, we now have one serving crew per meal working under direct supervision of the dietitians in our main kitchen.

Garbage from foods returned uneaten on patient trays has been materially reduced since our patients now eat more of the foods served them. All are now served at proper temperature, texture and flavor and are therefore more palatable. We also feel that the selective menus, made possible through central portioning, contribute greatly to reduced waste and better care.

Hospitals caring for the short-stay, acutely ill patient are usually alike in that patients must frequently be treated by doctors, nurses, x-ray, or other laboratory work at meal time. Without a vacuum sealing and temperature control system such as ours, delayed trays either become cold and unappetizing or very costly food waste and special handling become necessary. We have the controls on our infra-red dish heater adjusted to keep entree courses hot for one hour because we find that 95 per cent of all delayed trays are served within that time after preparation.

Time-tried . . We are very pleased with this new system after more than 12 months of usage. Naturally we faced several problems at the outset because the conversion was such a radical departure from former decentralized procedures. It

FIGURE 6 . . Completion of hot foods packing operation in foreground where entrees are vacuum-sealed by addition of upper half of container. In background trays are completed with salads, desserts, bread, butter, etc. Coffee cups, soup bowl, chilled juice tumblers, etc., are added to trays here but are left empty for filling later (see figure 8)

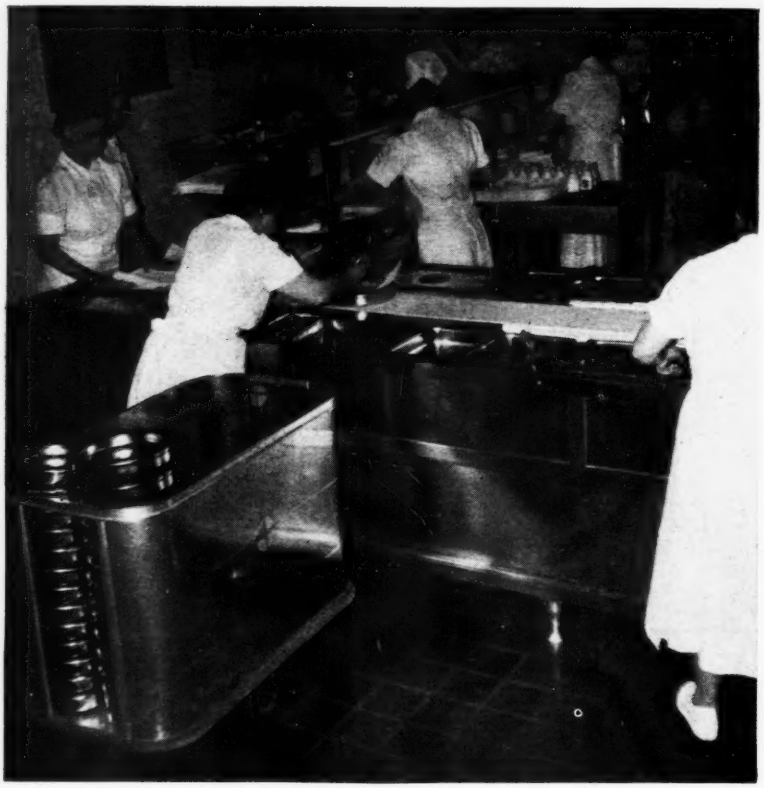


FIGURE 7 . . Completed trays inspected by tray checker and verified against selective menus which have accompanied containers and trays throughout assembly operation. Completed trays are then loaded into waiting tray carts at left for distribution to various nursing units. Note that hot and chilled liquid foods already are in insulated bulk dispensers on each tray cart

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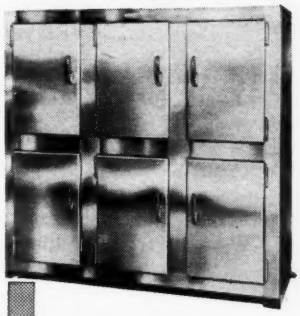
all metal construction throughout



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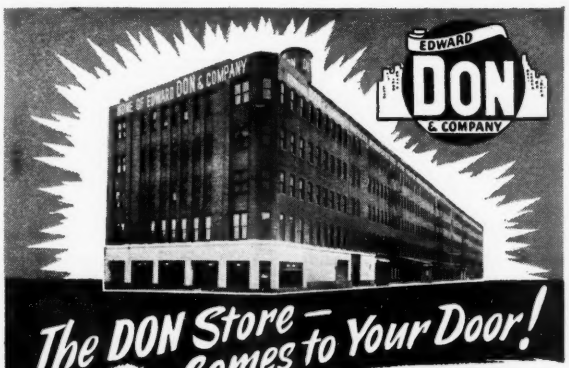

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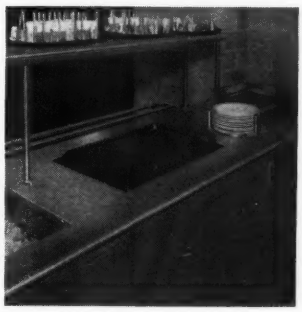
HOUSTON, TEXAS
Installs AMF LOWERATOR Dispensers

AMF Lowerator Dispenser floor models are loaded at the dishwasher with 10 to 14 dozen plates or 75 cups... then they are wheeled to the food stations at the cafeteria counter. This system speeds service by eliminating a great deal of handling and rehandling. Sanitation is improved. Breakage is reduced. Efficiency is increased.



In-Counter Type AMF Lowerator Dispensers hold 5 to 7 dozen plates and 125 to 200 trays. With such equipment, it is easy to handle the peak loads of the busiest periods.

Benefit from the experience of Hermann Hospital, Institutions Grand Award Winner. You, too, will improve your food service while cutting food handling costs when you install AMF Lowerator Dispensers.

SAVE SPACE • SPEED SERVICE • REDUCE BREAKAGE

Floor and In-Counter Models • Heated, Unheated and Refrigerated Units
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AMERICAN MACHINE & FOUNDRY CO., 485 FIFTH AVE., NEW YORK 17, N.Y.

Western Distributor—Dohrmann Commercial Co.

was necessary to devote time to intensive retraining of both dietary and nursing personnel during the first weeks of operation. We have also found it advisable to add new centralized dishwashing facilities.

Obviously this article cannot detail all of our new system or its many benefits. However, experiences during more than a year in operation now warrant our wholehearted recommendation of this service to all hospitals having a hot food problem or seeking a positive escape from the many problems encountered with decentralized methods. Although we cannot claim perfection, we feel that this system has brought us as near as currently possible to complaint-free food service . . from the standpoint of patients, doctors, nurses and personnel. Visitors to our kitchen to observe this service in operation will be most welcome.

In conclusion, we wish to acknowledge our indebtedness to our architect, Roland L. Linder; consultant, Dr. Herman Smith; and the Mealpack Corporation for their combined cooperation toward the success of this project. ■

Figure 8 . . Tray being taken to patient. Dietary cart girl at right has just added soup, coffee, chilled juice and possibly ice cream from insulated compartments of the cart to pre-set utensils on each tray. By adding these foods at the moment it is known the patient is ready for service, proper temperatures are assured. Note that tray is immediately adjacent to patient's bedroom to minimize distance trays need to be carried.

Letters

continued from page 17

the experience during the past few years.

4. We have reduced our overhead expenses from 14.6 per cent in 1943 to 8.4 per cent in 1951, and we expect further economies during 1952.

5. We have established a method of payment to hospitals during the past year which is based upon hospital costs.

6. We are providing subscribers the greatest amount of hospital care for their dollar in the history of our organization.

We heartily agree that the Blue Cross Plans must never relax their vigilance to maintain the highest possible standards. They must stay economically sound or there will be no Blue Cross Plans. With those positive objectives constantly in mind we don't believe the Minnesota Blue Cross Plan or any other need fear for the future.

Thank you for the opportunity to present these important facts.

Arthur M. Calvin,
Executive Director.
Minnesota Blue Cross, Blue Shield, St. Paul, Minnesota.

Britons to pay more for health services

■ The fiscal program for Great Britain presented to Parliament on Jan. 29 by Richard Austen Butler, Chancellor of the Exchequer, held special interest for Americans because of the proposals for imposing additional charges for various services formerly offered by the National Health Service free of charge to all comers.

Among these are a charge of one shilling for each prescription, estimated to produce an annual revenue of 12 million pounds; a charge of one pound or total cost, if less, for dental work, except for false teeth (for which patients now pay one-half of cost), with an estimated total revenue of seven and a half million pounds; and charges for such items as hearing aids, wigs and the like, as well as for private care in hospitals, all calculated to produce an additional 20 million pounds.

Mr. Butler is said to have declared that the real threat to the social services lies in the danger of national bankruptcy, not in the modest charges proposed. They will probably be adopted. ■

Yeasts and fungi . . in new strains being developed from fundamental studies of their natures, will give us better beer and bread and more potent penicillin.

Non-caloric sweetener . . sodium cyclohexyl sulfamate, can be cooked in food without losing sweetness as other synthetic sweeteners do.

—The Chemical Digest

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Unsalted Tomato Juice . . . Sugar Free Sweets . . . . Flours for Allergy Diets.

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PACKED IN NATURAL JUICE OR WATER

Brighten your diets with Cellu Canned Fruits. Over 16 varieties packed either in natural juice or water without added sugar. Food values are printed on labels to simplify diet measurements.

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Nursing teams

continued from page 107

with the same patients each day as nearly as possible and keeping the same members of the teams. It is essential that assignments be clear, in writing, and include enough responsibilities to efficiently utilize the services of all team members. While the professional nurse is receiving the report in the morning the nurse assistant is attending to the immediate needs of the patients. As soon as the professional nurse has written out her work slips, as well as those for the nurse assistant, she proceeds to present the general plan to the other team members.

It is necessary to recognize that team planning requires more time and more instruction than when each individual makes her own plan of care. Any plan must be flexible enough to allow for the many changes that arise from such things as changes in the condition of the patients, changes in the plan for medical care and the functioning of other departments in the hospital. The professional nurse sees all patients assigned to her as soon as possible and starts accomplishing the most essential things in her plan. In some instances team members will each give complete care to individual patients; in others they will work together, the nurse assistant always looking to the professional nurse for help and suggestions when needed.

The assignment of too many patients and too high a ratio of nurse assistants to one professional nurse will make this impossible. The ratio may vary according to the degree of illness of patients being cared for and the amount of activity on a particular ward. The activities in a teaching hospital, where students are learning and where research is conducted, adds to the load. It is also necessary to remember that the patient is part of the team and that his cooperation and understanding must be secured also.

Time sheet . . Let us look at a sample time sheet for an active surgical women's unit with an average census of 24 patients:

Women's Surgical Unit — Census: 24

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Head Nurse						Off	Off
Assistant Head Nurse				Off	Off		
Professional Nurse	Off	Off					
Professional Nurse			Off	Off			
Professional Nurse						Off	Off
Nurse Assistant	Off	Off					
Nurse Assistant			Off	Off			
Nurse Assistant						Off	Off
Clerk						Off	Off

Savory keeps toast orders moving!

Savory speeds up your toast service. It's so quick and easy to load, there's always room for loading on its continuously moving conveyor. And there's always toast for serving, too. It unloads itself automatically, so there's no waiting, no conflicts, no confusion — *just crisp, delicious toast;* as much as you want, as fast as you want it!

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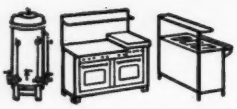
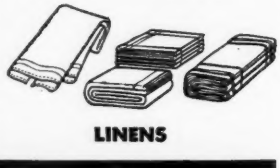


KITCHEN EQUIPMENT

KITCHEN UTENSILS

CLEANING SUPPLIES



LINENS

PIX is equipped to fill many of your hospital's equipment and supply requirements all in one place. And because many of the same items are also used by hotels, restaurants and other institutions PIX buys in quantity to obtain advantages in price and quality that are passed on to you. For equipment, linens, furnishings, uniforms and supplies you can be sure "If It's from PIX It's Right."

Write Dept. H

ALBERT PICK CO., INC.

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Figure Your DISPOSABLE TISSUES on a Strictly Cost Basis...

Then... Add up the Advantages of Wipettes® ABSORBENT TISSUE

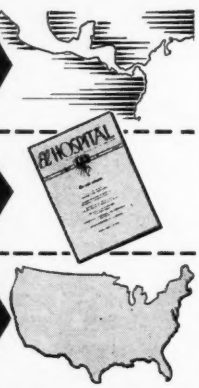
Order Wipettes from your surgical, hospital or pharmaceutical supply house.

Manufactured by The SANITARY PAPER MILLS, Inc.

In LATIN AMERICA

El HOSPITAL

IS A MAP OF THE···



UNITED STATES MARKET FOR HOSPITAL EQUIPMENT AND SUPPLIES

Latin-American hospital buyers consult it regularly to spot those North American manufacturers who show that they are anxious to serve good Latin-American accounts.

An advertisement in EL HOSPITAL is the quickest route to all the Latin-American hospital markets. For rates, write:

El HOSPITAL

THE INTER-AMERICAN HOSPITAL JOURNAL

PANAMERICAN PUBLISHING COMPANY, Inc.

570 7th AVENUE, NEW YORK 18, N. Y.

There are certain days when the nurses' and assistants' time overlaps. This time allows for flexibility to cover illness of team members, holiday time and to cover emergencies which may arise and which will affect the functioning of the ward unit as a whole.

In summarizing, it is apparent that the problem of insufficient staff must be met. We should each analyze our own situation. We know what staff we have to depend on at any one time and to some extent what we are able to recruit and it is up to us to figure out some plan to supply the quantity and quality of nursing care essential for the well being of our acutely ill patients in our hospitals in order that we can fulfill our responsibility to the community.

If the team plan for nursing service is to be utilized, it will be necessary to set up some means of selecting, training and orienting your personnel. It is suggested that you read the material available on the subject in order that you may profit by the experiences of others and that you may realize that the final answer is not available at the present time, but that we cannot be static in our methods if we are going to solve the problem. ■

New requirements for schools of anesthesia

■ CRITERIA of accreditation for schools of anesthesia for nurses were approved by the American Association of Nurse Anesthetists' board of trustees on January 19 at Chicago. The association's accreditation program became effective as of that date and schools established thereafter must comply with the new requirements at the time of making application for approval. Existing schools desiring full approval must conform by December 31, 1953.

The accepted criteria require that the course be of a year's duration and include 200 hours of classwork and 400 hours of clinical instruction. Requirements for clinical experience are spelled out in detail. In addition, a school desiring approval must comply with the association's bylaws in selecting students and complete a questionnaire and consent to inspection. ■

The radio voice of Lexington's hospitals

continued from page 47

outside Fayette County, of which Lexington is the county seat.

News of births is given the station just before air time, giving Stork News an on-the-spot quality the newspaper birth announcement cannot achieve. It is this immediacy which makes the program so popular with listeners. There is no waiting for this afternoon's or tomorrow morning's paper to learn who was born last night or early this morning. The show saves the hospital many calls for information about births from interested families and friends; and it also saves these friends and families the cost of local or long distance calls to the hospitals.

Telephone . . The station telephones each hospital at a regular time, about an hour before the broadcast, for the information around which Stork News is built, and which is its reason for being. The receptionist at each hospital relays the news she has just received from the nurse in charge of the maternity floor for this purpose.

The store delivers and calls for the radios requested by patients at its invitation, issued at least twice in the course of each edition of Stork News. It bought five dozen radios, all of the same make and all portables, for the exclusive use of the hospitals' maternity patients, and nearly all are in demand continuously. Both ward and private patients avail themselves of the service. The store keeps the radios in good working condition at all times.

Radios . . are of therapeutic value to the patients in several ways. Not only do they keep the patient in touch with what is going on in the world outside, but they are also beneficial in that they help prevent loneliness and a consequent impatience to leave the hospital. They make the period of convalescence seem to pass more rapidly. The hospitals encourage their use for these reasons, and in certain cases for others too.

Stork News is even more the hospitals' program than it is the store's. They and their patients are its subject matter. Conducted with simplicity and good taste, it is in keeping with the spirit of usefulness which both hospitals so thoroughly exemplify both to Lexington and to the dozens of smaller towns around which have no hospitals of their own.

The program may not bring any new patients to either Good Samaritan or St. Joseph's, but it is useful to them in another way: because of its informality and its cordiality it has increased the community's feeling of good will toward them. Stork News is indeed the "voice of Lexington's hospitals" . . a gentle, kindly, friendly voice, that serves with quiet, unobtrusive magnetism.

Rich Brown Delicious
GRAVY GIVES HOSPITAL MEALS A TOUCH OF HOME!

Patients perk up when they see—and *taste*—rich brown gravy made with Kitchen Bouquet. This unique blend of 14 garden-fresh vegetables, herbs and spices adds no artificial flavor. Used by good cooks and chefs for 75 years to bring out *true* meat taste and give gravy an appetizing, deep brown color.

Here's another tip: you'll save meat-shrinkage—get extra servings—by slow-roasting at 300°F. For rich brown crust, brush the meat, before roasting, with Kitchen Bouquet.

Always use Kitchen Bouquet to get the most flavorful meat gravy at only a fraction of a penny per serving.

FREE! "QUANTITY RECIPE" CARDS and 4-oz. Bottle Of KITCHEN BOUQUET.

Just drop a post card to: Kitchen Bouquet, Grocery Store Products Co., Dept. HM-3, West Chester, Pa.

KITCHEN BOUQUET

Available in pts., qts. and gals. For 2-oz. and 4-oz. sizes, see your grocer.

Ready in Just 5 Minutes

Recommended by Doctors!

Data* prove that delicious Cream of Rice gives (1) quicker nutrition; (2) more energy; (3) is easier to digest and (4) is least likely of all kinds of cereals to cause allergic reactions.

**Test data available upon professional request.*

hm

accounting and recordkeeping

Sorting checks for reconcilement: a fast, safe and simple method

by Wilfred K. Moran Comptroller • Hospital Service Corp. of Western New York

■ FOR A GOOD MANY small-to-medium-sized businesses, the problem of speedy, efficient check sorting has grown considerably over the past few years. Increased check usage resulting from increased business has meant that check-sorting methods previously suitable have been outmoded. Many establishments have therefore been forced to seek new techniques which would bring this recurrent routine task into line with other modern office methods from the standpoint of efficiency.

Blue Cross is no exception . . Not only has the Blue Cross Plan itself shown a marked increase over the last several years, but added to it has been the sharp growth of the newer Blue Shield program. Today, serving a seven-county area with a population of 1,300,000, the Hospital Service Corporation of Western New York has 612,000 Blue Cross members and 348,000 Blue Shield participants. On the other side of the ledger, we disburse payments to 34 hospitals under the Blue Cross Plan and to 1,300 member physicians (95 per cent of the active doctors in our area) under the Blue Shield Plan.

Although we in Blue Cross are constituents of an institution in a specialized field, our office problems are much like those of any manufacturer or sales company. Probably the only major difference is that our disbursement operations are larger . . in proportion to the size of our organization, which numbers about 200 . . than those of businesses of comparable size in other fields.

Check usage multiplies sorting problems . . We find it convenient to maintain four different bank accounts. On Bank No. 1 we draw checks for our regular accounts payable (vendors, etc.), our hourly payroll, refund account and payments to hospitals under Blue Cross. At Bank No. 2 we maintain an account for payments to physicians under the Blue Shield Plan. We draw on Bank No. 3 for a second group of payments to physicians and our executive payroll, while Bank No. 4 is used for our third group of physicians' payments.

In total, we issue over 2,600 checks a month. Yet this volume is handled by only five girls . . two in payroll and three (a supervisor and two assistants) for all general disbursements. This seems quite efficient, seeing that the check sorting problem is complicated by the multiplicity of banks utilized.

Advantages of reverse numerical table sort . . The sorting system we employ (suggested to us by the Todd Company, whose checks, check-writing and check-signing equipment we use) is known as the "reverse numerical table sort."

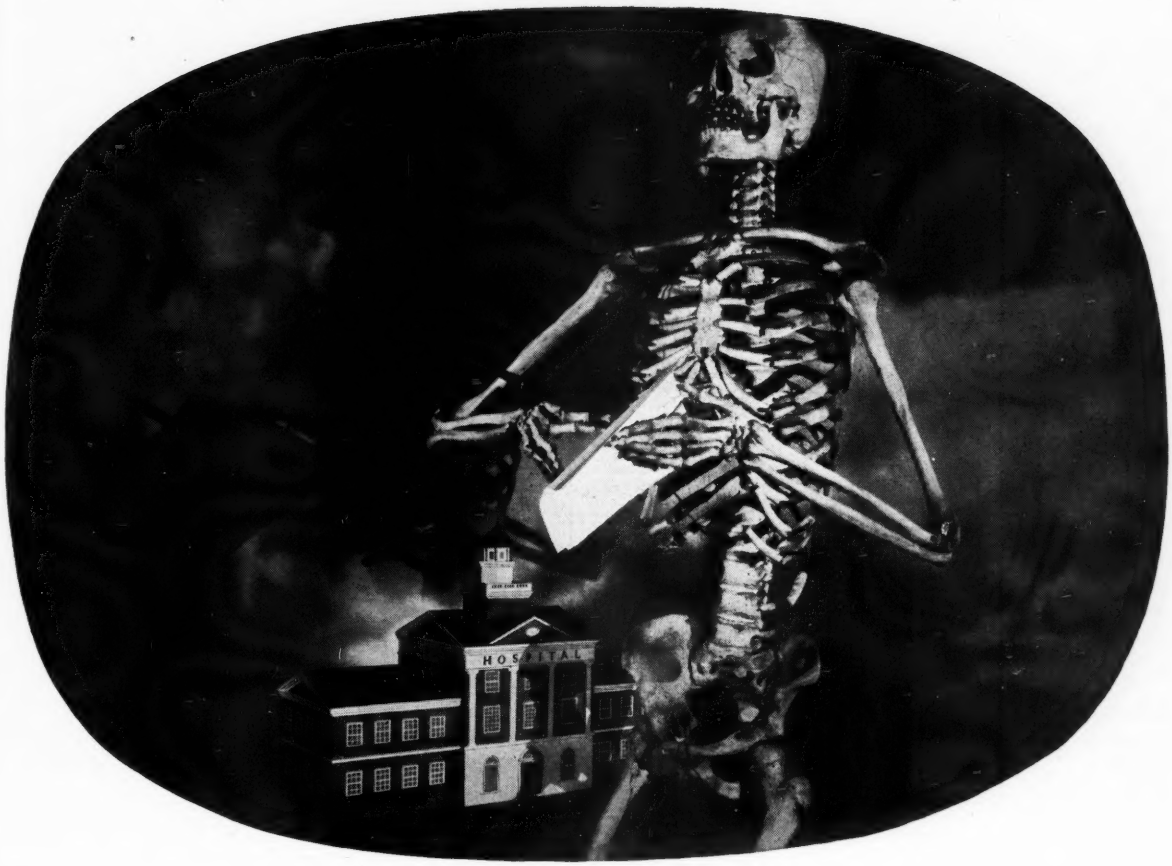
Using it, a girl can sort 100 checks in five or six minutes, averaging 1,000 an hour with no equipment other than her brain, eyes, hands, an ordinary office desk or table and the serial numbers already printed on the checks. This means that our monthly check load is completely sorted and ready for reconcilement in about two and one-half hours.

The system is simplicity itself. After an operator has tried a couple of practice runs, the chances are that she will be completely sold on it. Experience has shown that an untrained operator can master it in just a few minutes.

Here's how it works . . For example, let us suppose that the serial numbers run from 2348 to 2861, an even number of digits. The following steps are performed:

1 . . Taking a batch of checks in her hand, the operator sorts them into ten piles by the units digit of the serial number (the digit farthest to the right). All serial numbers ending in digit "0" go in one pile, all those ending in "1" in the next pile.

2 . . From rapid inspection during the first sorting she has determined that the serial numbers contain four digits, an even number. (Most firms' checks have either four- or



Have they cut your staff to the bone?

When a budget slice says something's got to give, it's usually your administrative staff that takes the skinning.

You *can* administrate a hospital with a skeleton staff—*if* you have a record-keeping system that means business.

Take McBee Keysort cards and machines for instance. They lighten work loads by increasing clerical efficiency and accuracy. Listing a patient's background, itemizing costs and recording information of all kinds becomes easy with Keysort Charge Tickets.

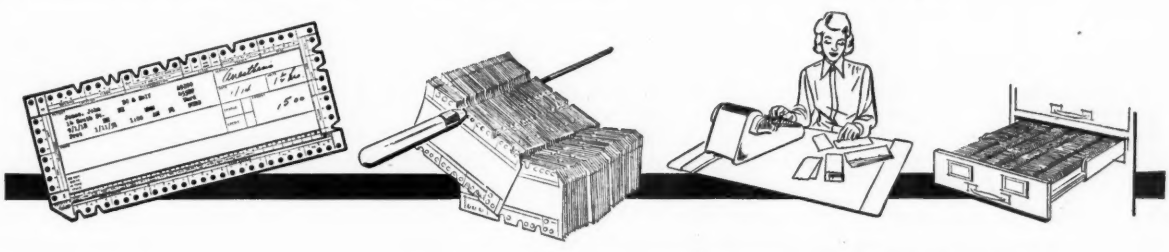
With existing personnel, *without* costly installations or major procedural changes, Keysort Charge Tickets provide complete cost-control information at less cost than any other method.

When notched, the pre-coded holes along the edges of each Keysort Charge Ticket make it easy to *collect* the facts on each patient . . . *classify* them . . . *file* them . . . *find* them . . . *use* them . . . quickly and accurately.

For analyzing expenses and income by contractual classifications, Keysort Charge Tickets, together with McBee Unit Analysis, furnish reports of current and cumulative figures.

Other McBee methods put your payroll, patients' ledger and inventory on a businesslike basis.

The McBee representative near you is trained to analyze your record-keeping problems and remedy them. Call him. Or write us.



THE McBEE COMPANY

Sole Manufacturer of Keysort — The Marginally Punched Card
295 Madison Avenue, New York 17, N. Y. ***Offices in principal cities.***

five-digit serial numbers . . few have checks numbered over 99,999.)

3 . . Reference to the "pick-up chart" (*right*) tells her that in picking up her ten stacks of checks the first time, she is to put the "9's" stack on top, the "8's" underneath, and so on to the "0's" on the bottom.

4 . . When the stacks of checks have been thus reassembled, the operator sorts again, this time sorting by the "10's" digit (second digit from the right).

5 . . This time, in picking up the stacks, the operator notes that according to the chart, all the "9's" go on the bottom of her new pile, the "8's" next, and so on.

6 . . The operator sorts the stack out again, this time by the "100's" digit (third digit from the right).

7 . . On the next pick-up she puts the "9's" stack on top again (as per directions on the chart).

Further operational considerations . . Almost always there will be a decrease in the number of piles with each sort. Seldom will the operator find that there are ten full stacks on each re-sort. In such cases, she merely arranges her stacks in descending or ascending order (as the case may be), skipping the missing numbers.

(The third, fourth and fifth sorts are very speedily handled by practically instantaneous inspection, but the complete procedure is outlined here for purposes of clarity.)

With four-digit serial numbers the checks are in exact numerical sequence on the fourth pick-up, all ready for reconcilement.

(If the serial numbers had contained five digits, an odd number, the operator would . . following the chart . . have placed her "9's" stack on the bottom after her first pick-up; the checks would then have come out in exact numerical order on the fifth pick-up.)

Simplicity, speed and safety are assets . . Although it takes quite a few words to describe the "reverse numerical table" system, one or two demonstrations following the method outlined here, in conjunction with the chart illustrated, will show the extreme simplicity of this fascinating little "trick" which can be learned in a few minutes by a child of grammar school age.

Simplicity is one of the greatest virtues of this procedure. New employes can be trained in it very quickly, and soon develop a speed matching or surpassing that of far more complicated systems requiring special equipment.

Besides simplicity and speed, however, there is another asset . . *safety*. Since the checks are sorted individually, not by batches, each comes under individual inspection, so forgeries or alterations have a better chance of detection.

Moreover, arranging the checks in numerical sequence in the original sorting means the elimination of such a sorting at any other time. (As you know, auditors sometimes ask to see them thus arranged.) With our system, the job is done once and for all.

PICK-UP CHART
For Reverse Numerical Table Sort

Pick-up of Checks	For EVEN No. of Digits in Serial Number	For ODD No. of Digits in Serial Number
First Pick-up	Put "9's" Stack on TOP	Put "9's" Stack on BOTTOM
Second Pick-up	"9's" on BOTTOM	"9's" on TOP
Third Pick-up	"9's" on TOP	"9's" on BOTTOM
Fourth Pick-up	"9's" on BOTTOM	"9's" on TOP
Fifth Pick-up	"9's" on TOP	"9's" on BOTTOM
Sixth Pick-up	"9's" on BOTTOM	"9's" on TOP

Recommendation . . Some offices, modern in all other respects, have not been streamlined with regard to check sorting because:

- Some are not aware of the advances that have been made in sorting, or
- Officials feel that new systems are too complicated or too extreme for disbursing the needs of medium-sized operations.

Personally, I am convinced that if more financial officers knew about the merits of the "reverse numerical table sort" . . speed, simplicity and safety . . they would use it to advantage in cutting costs and promoting control in check reconcilement. ■

American Association of Hospital Accountants' Institute on Accounting scheduled for Indiana University in July

■ ARRANGEMENTS HAVE BEEN COMPLETED for the 10th Annual Institute of Hospital Accounting sponsored by the American Association of Hospital Accountants.

Sessions will be held at Indiana University, Bloomington, Ind., during the week of July 13-18. Detailed brochures, now in preparation, will be available upon request.

Last year's Institute was attended by 129 members from 30 states and Canada. Unfortunately, at that time, it was necessary to turn down 40 applicants due to limited accommodations. This limitation has been rectified, and there will be facilities available for a potential attendance of 200, so that officials of the organization fully expect another sell-out.

Every phase of hospital accounting will be covered in the lectures, panel sessions and question periods. It can be confidently predicted that the 1952 sessions will prove as rewarding as those last year. ■

Ratio of collections to patient charges

by
F. James Doyle
Editor,
How's Business
Department

■ THE MOST COMMON ERROR in regard to the interpretation of the statistics printed each month in the How's Business department of this magazine, is the assumption that the figures are representative of a balance sheet.

A hasty or uninformed reader, noting on page ten that "Operating Income Per Patient Day" is in many cases larger than "Operating Expenses Per Patient Day," would wonder why the majority of the nation's hospitals are in the red.

As a matter of fact, the phrase "Operating Income" is somewhat misleading. This figure actually denotes "Charges to Patients" . . which is the wording used on the questionnaire sheet sent to cooperating hospitals.

Those concerned with the operation of hospitals know, moreover, that there is a considerable difference between the amount billed to patients and the amount collected . . due to allowances, discounts, uncollectible accounts, and other factors.

Not to substantiate the existence of this unfortunate differential . . which is universally acknowledged to exist . . but to ascertain its extent, one of the "questions-of-the-month" on the back of the form sent to respondents of the How's Business section was devoted to this situation.

The question . . The inquiry was worded thus: "On an average, what percentage of the monthly billing is collected?" The range of answers was astonishing, reaching from . . believe it or not . . 25 per cent to 99.72 per cent.

Of the respondents sending in completed How's Business forms, only 99 answered this additional inquiry, but since these represented every geographical region and each of the three size-divisions (number of beds: 1-100, 101-225, and 225-up), the results may be considered fairly representative of the nation's voluntary general hospitals.

The answer . . The national average for the percentage of billings actually collected proved to be 87.92 per cent.

The regional break-down was as follows:

New England	**80.42**
Middle Atlantic	**90.93**
South Atlantic	**76.30**
South Central	**93.20**
East North Central	**90.70**
West North Central	**85.92**
Mountain States	**95.83**
Pacific Coast	**90.06**
NATIONAL AVERAGE	**87.92**

These figures should cause no astonishment among those in the business offices of hospitals (since it was precisely those individuals who submitted them). Such statistics may, however, be an eye-opener to the general public, which is so concerned about the high cost of hospitalization. ■

Due to the interest in the intimate relationship between the salaries or wages paid personnel and the total cost of hospital care, a short analysis of this ratio will appear in the April issue of 'hm.' Watch for it, and compare the percentage of total expense you devote to personnel compensation with that in your geographical area and with the national average.

Comparison of the buying power of 1939's salaries and today's

■ WHEN PRICES GO up . . *up* . . UP, the customer's purchasing power goes DOWN . . *down* . . down. As automatically and inevitably as reaction follows action, the ability of the dollar to obtain goods decreases as inflation mounts. A glance at the figures below may enable administrators and trustees to consider more sympathetically employes' salary increases. The group between top executives and unionized labor seems to get squeezed worst by spiraling costs and steep taxation.

Consider the following data, which represent the net income required to give the same buying power after taxes as in 1939 (the figures are for a married person with two dependents).

Net income: 1939	1945	1949	1951	1952
$ 3,000	$ 4,516	$ 5,681	$ 6,461	$ 6,558
5,000	7,990	11,232	11,232	11,480
10,000	18,470	24,233	24,233	25,224
15,000	33,429	32,642	40,198	43,524

Such statistics speak, rather bitterly, for themselves. ■

x-ray special departments

How dental clinics are functioning as part of hospital picture

■ A UNIQUE DENTAL CLINIC is in operation three nights a week at Northern Liberties Hospital, Philadelphia, Pa., which is providing free dental service to underprivileged children in the substandard Poplar area of Philadelphia.

Six agencies are cooperating in the program, according to Herman R. Goldberg, administrator. These agencies are the University of Pennsylvania School of Dentistry, the Friends Neighborhood Guild operating through the Poplar area Health and Welfare Council, the public school nurses, Independence chapter of the National Association of Secretaries and Northern Liberties Hospital.

Children less than 16 years old who otherwise would be unable to get dental care are treated by senior and junior dental students, members of Psi Pi Fraternity of the University of Pennsylvania, under the supervision of a university instructor and the Northern Liberties Hospital dental department, using the hospital's facilities and equipment.

In the first 10 months of operation 112 children were treated, 21 of them having completed treatment. Nurses have referred children from 13 schools in the area to the hospital's social service department.

If the dentists found need for extraction of teeth instead of operative work, which is done in the night clinic, the patients were referred to the hospital's regular daytime clinic. In this way a complete service could be offered.

A secretary in the office of the Philadelphia County Dental Society brought the project to the attention of the organization of secretaries, which sent 65 members as volunteers to serve as receptionists, arrange appointments, keep records and take social histories.

If other hospitals would like to offer a similar service Mr. Goldberg points out that participating groups assume all responsibility. For instance, the Friends Neighborhood Guild provided representatives to be on duty at the clinic from 6:30 p.m. to 9:30 p.m. A volunteer social worker handles charts, and funds must be provided to underwrite additional clinic expense, including additional equipment.

The fraternity provides a university instructor as sponsor. Three senior or junior students are available each night the clinic is open. Students bring their own instruments. It is understood that the clinic must be left in good order. The instructor is responsible for the work of the students and he is responsible to the chief of the hospital's dental staff.

The hospital provides a fully equipped dental clinic of two chairs, an x-ray machine, a dark room for developing emergency x-rays, heat and light, hot and cold water, sterilizers, three uniforms nightly for each clinic, materials for fillings, x-ray film and medicaments. The hospital also supplies charts, maintains records and additional equipment as needed.

A member of the hospital board

New dental clinic . . recently opened at Montefiore Hospital, New York City

above everything

KELEKET *Exclusive* Ceiling-Mounted X-ray Tube Crane

Clear the floor for action with the Keleket *Exclusive* Ceiling-Mounted Tube Crane. Suspended entirely from the ceiling, it offers effortless convenience in every radiographic and therapy technic.

The Keleket Tube Crane does more than the ordinary tubestand and it conserves valuable floor space. There are no rails on the floor, no obstruction whatever to the operator's complete freedom. The layout of your radiographic facilities becomes much more flexible with the Tube Crane.

Brought to practical reality by Keleket, the Ceiling-Mounted Tube Crane offers unparalleled tube manipulation, three stereoscopic shifts, fingertip positioning and precise indication of angulation.

Write for FREE brochure

KELEKET X-RAY CORPORATION

208-3 W. 4th St., Covington, Ky.

(Kelley-Koett .... The Oldest Name in X-Ray)

Export Sales: Kelley-Koett International Corp., 215 East 37th Street, New York 16, N. Y.

represents the board in supervising the clinic. The hospital's medical director serves in a consulting capacity. A dental hygienist may be made available later on a voluntary basis. The chief of the hospital's dental staff, who is responsible for the night clinic, is in constant consultation with the university instructor sponsoring the students. ■

New dental clinic at Montefiore

■ A NEW DENTAL CLINIC has been opened by Montefiore Hospital in New York City, continuing and expanding dental department services inaugurated 30 years ago, according to Martin Cherkasky, M.D., director of the hospital.

The new clinic, embodying the most modern equipment including dental chairs which can be easily wheeled away to make room for patients in stretchers and wheelchairs, is housed in an eight-room suite. It contains five mobile treatment chairs and units, a surgery room, a "recovery room," an x-ray department and complete laboratory facilities so all types of bridges, dentures and oral prosthetic appliances can be manufactured there.

A staff of four interns and 38 attending dentists assists Dr. David Tanchester, chief of the dental department, in providing more than 7,000 treatments a year to Montefiore's ward patients and those attending the hospital's many clinics. The facilities of the dental department also are available to those patients being cared for under Montefiore's home care and family health maintenance plans.

Dr. Tanchester, who has directed the dental unit at Montefiore Hospital for 30 years, also is clinical professor of oral surgery at New York University and clinical professor of dentistry at Columbia U. ■

Dentistry in hospitals

by Karl Hayden Wood, Ph.G., D.D.S., F.I.C.D., F.A.C.D.
Associate in Dental Surgery
School of Medicine, University Hospital
George Washington University
Washington, D.C.

■ DENTISTRY is an important part of the health service of any community. Since dental care is often a necessary part of the treatment of hospitalized medical and surgical cases, both private and indigent (as bed patients and clinic patients), cooperation between the physician and dentist is imperative in the modern hospital organization. In addition, there are patients who are admitted primarily for the treatment of oral conditions. For example, the repair of traumatic injuries about the jaw, or the surgical irradication of oral infection of dental origin. These patients should have the benefit of an efficient and capable dental service.

For many years individual dentists have cooperated with the medical profession in hospitals as staff members in the outpatient department for care of the indigent.

Surgery . . Major oral surgery on George Washington University Hospital patient

Committee set standards . . Until recently, there has been no true coordination between the national organization of dentistry, known as the American Dental Association, and the dental departments of hospitals. But in 1944 the American Dental Association formed a committee known as the Hospital Dental Service Committee. This committee set up certain standards required of all dental divisions in hospitals, and of the hospitals themselves, if the dental division of that hospital is to be recognized. The writer, who has had the privilege of serving on this committee in Washington for two years, can truthfully state that establishment of these standards has been an important step. It is paramount now that hospitals, which wish to have dental departments recognized, maintain standards required by the American Dental Association Hospital Dental Service Committee. Dental interns and residents must be of the highest caliber to maintain dental departments on a par with other departments in the modern hospital.

Clinic . . Examination of a patient in the G. W. U. Hospital's oral surgery clinic

It is the desire of the hospital committee that all branches of dentistry eventually become part of the dental services of hospitals. This would mean the addition of such specialties as radiodontics (x-rays), oral surgery, operative dentistry, periodontics, orthodontics (straightening of teeth), children's dentistry. The manpower required for this expanded program cannot be secured at the present time, and most hospitals do not have adequate facilities for these numerous services. Accordingly most dental services in hospitals are limited to oral surgical procedures.

Board of oral surgery . . The specialty of oral surgery is defined by the American Board of Oral Surgery as follows: "That branch of dental practice that deals with the diagnosis, treatment, prescribing for, or operating upon any disease, in-

continued on page 142

We need 3000 Carloads of Scrap a Day

Every pound of dormant scrap you can furnish will help to keep the steel mills and foundries producing

Steel mill furnaces are gobbling up scrap faster than it's being delivered. To maintain planned schedules of steel production for both military and civilian purposes, the mills must have *more* iron and steel scrap.

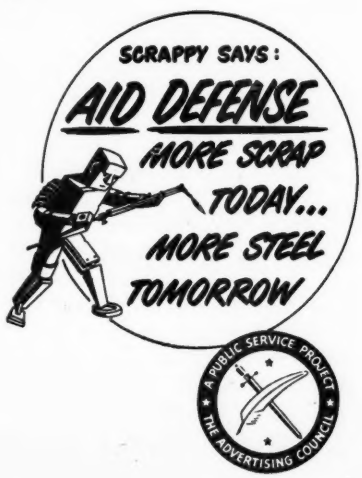
Get in the Scrap—Yourself!

Whatever your business, you undoubtedly have scrap. If there's dust on it or rust on it—it may be scrap. If it's scrap—it's *needed.*

Turn it over to your local scrap dealer and help lick this critical scrap shortage.

What you can do to help

1. Appoint one top official in your plant to take full responsibility for surveying the plant and getting out the scrap.
2. Consult with your local Scrap Mobilization Committee about its program to help out in the scrap crisis. The nearest office of the National Production Authority, Department of Commerce, can tell you who your local Scrap Mobilization chairman is.
3. Call in your local scrap dealer to help you work out a practical scrapping program. Non-ferrous scrap needed, too!
4. Write for free booklet, "Top Management: Your Program for Emergency Scrap Recovery", addressing Advertising Council, 25 W. 45th St., N. Y. 19.



FACTS YOU SHOULD KNOW ABOUT STEEL PRODUCTION

Steel production	1950	97,800,000 net tons
Estimated capacity	1952	119,500,000 net tons
Purchased scrap used*	1950	29,500,000 gross tons
Estimated purchased scrap requirement*	1952	36,200,000 gross tons

*All consumers

This advertisement is a contribution, in the national interest, by

HOSPITAL MANAGEMENT

product news

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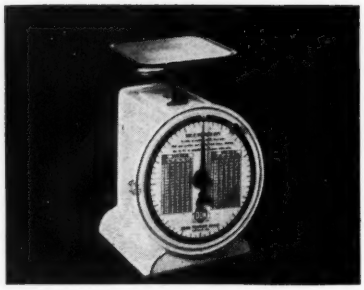


New office equipment

■ THERE IS an important saving in both time and cost that the new American Automatic Typewriter Co.'s new Auto-typist can bring to the hospital office. On repetitive correspondence, such as form letters and collections a saving up to 40% may be expected. Operation is simple . . and fill-ins, such as dates, names or places, may be inserted manually. Types at 2½ times the manual rate without error.

Circle 301 on mailing card for details.

How to modernize inexpensively

■ THE LOW COST of the new Marlite Hi-Gloss prefinished wall and ceiling panels will enable hospitals to create beautiful, maintenance-cutting interiors while holding remodeling expenses to a minimum. Available in a complete range of striking colors, this new wall panel material by Marsh Wall Products is installed quickly and easily . . without messy plaster dust or paint odors to contend with.

Circle 302 on mailing card for details.

Hold down food cost

■ FOOD PORTION CONTROL is made easy with a new scale introduced by Edward Don & Co. The scale has a 1-lb. capacity, is very sensitive and accurate. The dial has a clear, easy-to-read table of food portion costs and, with weight and cost per pound known, it instantly shows the cost per portion. Simple instructions for maintaining a 40% food cost are printed on the face. Will quickly pay for itself in savings.

Circle 303 on mailing card for details.

Potent detergent

■ A NEW, highly concentrated detergent, especially formulated for silverware washer and driers, brush glasswashers and hand dishwashing operations, is being introduced to the food service market by Foley-Irish Corp. The new detergent is so concentrated that a heaping teaspoonful is recommended in place of the tablespoonful previously used. Smaller packages are convenient to use, easy to store.

Circle 304 on mailing card for details.

New fire fighter

■ IMMEDIATE FIRE-FIGHTING efficiency is promised by a non-inverting, pressurized, water-type extinguisher just introduced by General Pacific and General Detroit Corps. The manufacturers say that inexperienced operators can operate this extinguisher deftly and expertly because of its squeeze grip control and the panic-proof rip puncture pin which insures that discharge will take place, once seal is punctured.

Circle 305 on mailing card for details.

Congratulate new mothers

■ OFFER CONGRATULATIONS to new mothers with this cleverly designed pink and blue tray ensemble designed by Aatell & Jones, Inc. Suggested for use on second or third day of hospital stay the set includes paper tray-doilie and napkin. Space is provided for writing the hospital's and patient's names. A clever patient relations plan for the maternity floor.

Circle 306 on mailing card for details.

Scrubber-polisher improved

■ AMONG THE MANY new operational and structural innovations in Lincoln-Schlueter Floor Machinery Co.'s single disc scrubber and polisher the self-retractable wheels which raise automatically with a slight tilt of the handle are especially featured. With wheels in "up" or "down" position, the operator can roll the machine from one floor area to another.

Circle 307 on mailing card for details.

Handy lab cart

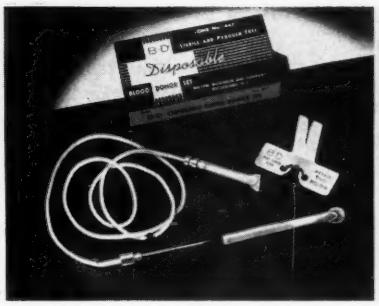
■ IN MANY WAYS this specially designed new stainless cart for laboratory use, by Lakeside Mfg., will save time and work for laboratory personnel. All types of fragile equipment are easily and safely wheeled from place to place. Shelves have a 2" guard rail on all edges and are insulated to deaden noise. Sturdily constructed for years of service, the cart is still easy-to-handle.

Circle 308 on mailing card for details.

Safe trays cut breakage

■ THIS CONVENIENT and safe method of storing and handling thermometers, hydrometers, volumetric and measuring pipettes is now offered for the first time. Laboratory Industries, Inc. makes all trays with three sets of finger cutouts for easy removal of glassware. The entire tray is completely covered to provide a soft cushion. Stor-Safe trays will pay for themselves by eliminating breakage.

Circle 309 on mailing card for details.



Disposable and inexpensive

■ WITH THE STATEMENT that "it is inexpensive enough to be *really* disposable," Becton, Dickinson and Co. has introduced a new Blood Donor Set for blood bank use. The B-D Disposable Blood Donor Set consists of a 24-inch length of B-D Plastic Tubing with an intravenous needle attached to one end and a stopper-puncturing needle to the other, and the set's special holder-clamp.

Circle 310 on mailing card for details.

Hospital communications

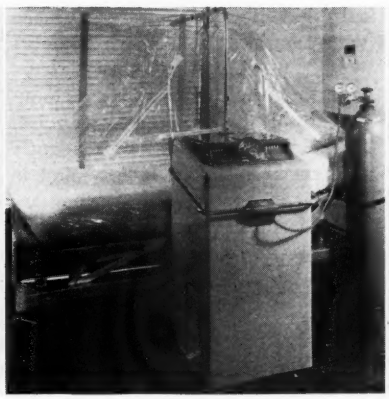
■ THIS NEW INTERCOM can increase administrative efficiency and serve to free telephone lines for important calls. Natural-voice communication is provided by this new low-cost, telephone-type intercom, Modern Minor, by RCA Victor. Provides from two to six stations, with code ringing or individual ringing, as desired. Easy to operate, it can be quickly installed for desk or wall use.

Circle 311 on mailing card for details.

Individual beverage server

■ THE NEW UNIVERSAL individual two-cup beverage server keeps liquids hot or cold, and is now available for hospital use. Especially ideal for tea serving, this thermal server ends complaints of "cold coffee or tea." Its sturdy, long-lasting shell and replaceable moulded plastic liner may soon make the server pay for itself in reduced breakage costs.

Circle 312 on mailing card for details.



New equipment line begun

■ THE FIRST major item in the new Melco line of medical equipment is an efficient new electrically-cooled oxygen tent. The full-bed transparent canopy has a new canopy clamp that is said to be quicker, surer and easier. Waist-level oxygen connections lessen danger of kinking and Melchior, Armstrong, Dessau Co., manufacturer, says servicing is simplified.

Circle 313 on mailing card for details.

Heavy-duty scale

■ PERFECT FOR USE in any location where a heavy-duty, easy-to-read personal weight scale is desired is this new Weigh-Master Model No. 700 by Hanson Scale Co. The new hi-dial scale has a capacity of 300 pounds and requires a minimum of floor space. There are probably several locations in your hospital where this new scale would prove particularly convenient.

Circle 314 on mailing card for details.

Outdoor entrance lights

■ EFFICIENT AND ATTRACTIVE are the new lamps designed with weather-proof construction especially for use at building entrances, driveways and gate entrances by The Art Metal Co. Dirt, dust and moisture are sealed out of the lamps and the heavy pressed clear prismatic glass transmits light with minimum absorption and resists breakage.

Circle 315 on mailing card for details.

Personalized package

■ A UNIQUE PERSONALIZED bottle now packages the well-known body massage, Derma-Fresh, sold exclusively by American Hospital Supply Corp. Your hospital's name is ceramically marked in fresh green with a professional looking design. The new identification adds prestige, creates respect and reduces loss to the hospital.

Circle 316 on mailing card for details.

Artificial respiration

■ A NEW DEVICE in the emergency equipment line, the Pneolator, has been designed by Mine Safety Appliances Co. to provide automatic artificial respiration. The unit operates without suction, inflating the lungs and then automatically "cutting off" to permit natural relaxation of the lungs and diaphragm to induce exhalation.

Circle 317 on mailing card for details.

Shaped for tray service

■ A DISTINCT ADVANTAGE of a rectangular shape in a divided paper plate has been introduced by Bowes Industries, Inc., manufacturers of Bondware plates. The plate is deep and divisions higher than ordinarily seen in compartment plates. The eating surface is smooth, hard, resistant and gleaming white. The rectangular shape is particularly perfect for hospital tray service as it takes up less space on the tray.

Circle 319 on mailing card for details.

Assure bathtub safety

■ YOUR PATIENTS DON'T SLIP in bathtubs and showers that are equipped with amazing, inexpensive "Safety-Walk" treads. The ten "Safety-Walk" non-slip treads in the shower-end of this tub grip your feet like a fine sandpaper. Permanently and easily installed by pressing in place, adhesive-side down, they are made from a water-proof fabric by Minnesota Mining and Manufacturing Co.

Circle 320 on mailing card for details.

Stops wall seepage

■ FLEXTITE, a liquid chemical to be mixed with cement, has been improved by the addition of a new stabilizing ingredient that speeds up action in sealing off leaks and water seepage in concrete walls. Manufactured by Flexrock Co., the new Flextite produces a mortar that is easily handled and fast-setting.

Circle 318 on mailing card for details.

Modern windows for hospitals

■ ALTERED TO MEET the requirements of modern construction, the new Rusco Combination Window is a trim, streamlined, efficient window unit that is extremely practical, durable and trouble-free. This handsome modern window unit by F. C. Russell Co. is simple to install, results in low field costs and provides year 'round protection, comfort and convenience. Entirely practical for hospital construction.

Circle 321 on mailing card for details.

Save with new refrigeration

■ THE UNI-FRIDGE PANEL, a self-contained unit, is designed for refrigeration of beverages, produce, meats and other perishables. The unit requires only two hours for installation in most walk-in coolers and boasts substantial savings on equipment cost and installation charges besides claiming to be as efficient as any remote installation.

Circle 322 on mailing card for details.

Permanent glove marking

■ AN ENTIRELY NEW METHOD of size marking surgeons' gloves has been developed by Massillon Rubber Co. to provide permanent size identification for the life of the glove. Marking is cured right into the rubber surface and can be readily seen when glove cuffs are turned back for pack sterilization, making pair matching easy and accurate.

Circle 323 on mailing card for details.

For surgical procedures

■ CLAY-ADAMS CO. now has animal-tested polyethylene plate and film available. Polyethylene film is being widely used in surgical procedures as an artificial membrane and to prevent adhesions. The principal use to date of polyethylene plate has been in cranioplasty, but use in reconstructive surgery is being studied.

Circle 324 on mailing card for details.

names & news of suppliers

hm

New ethical ad agency formed

■ HENRY F. BRANSTATER, formerly a partner in the advertising firm of Branstater-Hammond, has announced that he will continue in business as an ethical advertising agency under the name of Branstater Associates, Inc., at 11 East 44th St., New York. Mr. Branstater is well known in the field, and handles the advertising of a number of concerns interested in the hospital and related markets.

Sloan awarded contract for fireproof materials

■ W. & J. SLOANE, New York, has been awarded the contract to furnish and install all the draperies and bedspreads for United States Line's new luxury liner, "United States." As, of necessity, all the fabrics must be fire retardant, there were intricate technical problems in selecting materials that either would be fireproof or would withstand the fireproofing process. Many of the materials will be especially designed and woven for the ship.

Sharpe & Dohme opens Philippine subsidiary

■ WITH ELPIDIO QUIRINO, president of the Philippines, as principal speaker, the new $500,000 pharmaceutical manufacturing laboratories of Sharp & Dohme (Philippines) Inc. were officially opened recently in Manila at special ceremonies. Host at the opening was Albert R. Denmark, general manager of the new subsidiary, which is the first American ethical pharmaceutical manufacturing plant actually operating in that area.

A.I.C. honors Abbott president

■ DR. ERNEST H. VOLWILER, president and general manager of Abbott Laboratories, North Chicago, Ill., was presented with an honorary membership in the American Institute of Chemists at a meeting of the Chicago chapter on Feb. 1. The citation accompanying the honorary membership commends Dr. Volwiler "for his great service as a leader in the chemical profession and for his contributions to better cooperation among chemists."

Parke, Davis & Co. to expand world-wide facilities

■ PARKE, DAVIS & CO. plans to expand its world-wide facilities substantially during the next five years, one of its executives revealed recently in a talk before the American Pharmaceutical Manufacturers' Assn.

John A. MacCartney, trade relations manager for the 85-year-old firm said, "We plan to greatly expand our facilities during the next five years. This will include a new plant now nearly completed at Holland, Mich.; new laboratories in Buenos Aires, Australia, Havana, Canada and at several other domestic and foreign locations; enlargement of our plant in Mexico; new branch distribution warehouses and offices in Atlanta, Miami, New York, Teterboro, N.J., Albany, N.Y., and other domestic locations; enlargement of our Detroit plant by new product development buildings; new research facilities; and a new medical center.

"In addition, we are completing plans for the manufacture of at least some of our products in India, Germany, Japan and Italy."

Hoffman agency handles American Safety Razor Co.

■ THE AMERICAN SAFETY RAZOR Company of Brooklyn, N.Y., has announced that its advertising will be handled by Hoffman Advertising, Inc., of New York, with Kenneth E. Hammond, executive vice-president of the agency, as account executive. Mr. Hammond is thoroughly familiar with the hospital and medical fields, having for many years worked with companies whose products are marketed to these groups. He recently became associated with the Hoffman agency following the dissolution of Branstater-Hammond, an advertising agency partnership with Henry F. Branstater.

Other news . . Frank R. Koslicki and Harold L. Thomas have been named managers of Winthrop-Stearns Inc. Professional Service offices in Chicago and San Francisco, respectively.

Covering the states of Washington and Oregon for Troy Laundry Machinery Co., East Moline, Ill., is Lawrence Gillen, recently appointed sales representative for that area. New sales representative in the western Pennsylvania territory is B. C. Kocaka.

John R. McDermott has been promoted to assistant sales manager, commercial appliance department, Toastmaster Products Division, McGraw Electric Co.

A member of the team of scientists at Chas. Pfizer & Co., Inc. who discovered terramycin, Dr. Peter P. Regna, has been elected a Fellow of the New York Academy of Sciences.

Edward Don & Co., distributor of institutional furnishings, food service equipment and supplies, has acquired Perlman Supply Co. The Perlman company has specialized in fine glassware and china for 75 years.

Maurice L. Clancy has been appointed director of sales of Wyeth International Limited, Inc.

Lyman S. McKean, former Missouri director of public relations for a national industrial foundation, has been named director of public relations of American Hospital Supply Corp., Evanston, Ill.

Anesthesia . . Oral surgery resident administers anesthesia, under supervision

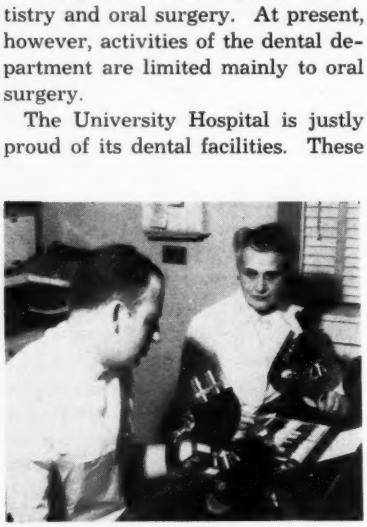
continued from page 136

jury, malformation or deficiencies of the human jaws or associated structures." The American Board of Oral Surgery, organized five years ago to examine and certify oral surgery specialists as Diplomates of the Board, is in keeping with the practice of medical groups who maintain specialty boards and thus insure the best possible care for sick people. Oral surgery is now recognized as a major dental specialty and is held in high regard by hospital administrators just as are the medical specialties of otolaryngology, surgery, internal medicine, ophthalmology, anesthesiology, and pathology.

One of the requirements of the Board of Oral Surgery is that the applicant for membership shall have had two years' internship in a hospital which has a recognized department of oral surgery. This requirement not only insures that the intern or resident, after he has completed his tour of duty in the hospital and begins his practice in the specialty of oral surgery, is well trained but also is of benefit to everyone in the hospital. Other medical services are aware that a competent resident in oral surgery is always ready to cooperate with them in his field. The patient who enters a hospital where there is resident training in oral surgery can be sure that the house doctor in this field has been selected for his ability, his professional manner, and his ethical attitude toward his patients and fellow practitioners.

Dentistry at the hospital . . At George Washington University Hospital there are: a full-time resident in oral surgery, two local general practicing dentists on the staff, and the chief of the department. Too, there are dentists who have privileges to bring private patients to the hospital, for both general dentistry and oral surgery. At present, however, activities of the dental department are limited mainly to oral surgery.

The University Hospital is justly proud of its dental facilities. These



Diagnosis . . Oral surgery resident sees slide collection bearing on oral diseases

consist of a small office, a recovery room, an x-ray dark room, two operating rooms, x-ray apparatus and fine accessory equipment. This was secured in 1948 when the new hospital was opened and the dental residency program established. The dental department of the hospital holds a certificate of approval from the Hospital Service Committee of the American Dental Association and is accepted for resident training in oral surgery by the American Board of Oral Surgery. The hospital staff is able to select its resident dentists from a large list of applicants.

Qualifications of oral surgery residents at the University Hospital have been excellent. Last year, the resident dentist was preparing for certification by the American Board of Oral Surgery. He had had one year of internship, together with one year of postgraduate study in oral surgery, for which he had received a Master of Science degree in Dentistry. This year's dental resident has had a year of internship at Bellevue Hospital and comes to us with a fine academic record. He is upholding the principles which we encourage at this hospital, and he is doing much to demonstrate to our other departments that the Department of Oral Surgery is essential to the health and well-being of the hospitalized patient.

Duties of the resident in oral surgery are not limited to time spent at the dental chair or in the operating room. During the first eight months of his training, mornings are spent in the operating room in the department of anesthesiology, and two evenings a week in attending lectures in anesthesiology. During the last three or four months, the mornings are spent in the pathological and hematological departments. The dental resident also attends staff conferences of the hospital. Here he learns more about the activities of the medical departments with which he must work. Afternoons are spent in the outpatient department dental clinic where oral surgical procedures are followed on patients who come to the clinic for a specific ailment in the dental field. Conferences and consultations are held with the medical residents regarding their mutual patients. The resident makes hospital rounds to visit dental staff cases. One afternoon a week is spent at the University Tumor Clinic at Warwick Memorial. Each of the medical departments (oncology, anesthesiology, pathology and hematology) with which the dental resident works at the university is headed by a nationally recognized specialist.

The oral surgery department is "on call" 24 hours a day for emergency care. This is accomplished through an unusual arrangement with Emergency Hospital and Episcopal Eye, Ear, and Throat Hospital in this city, both of which have excellent departments of oral surgery. Residents and interns of these two hospitals, in cooperation with the University Hospital, alternate "night on call" time in such a way that the three hospitals are never without a dental intern or resident.

Why hospitalization . . What types of cases are treated by the oral surgeon? Why is it often necessary for a patient to be admitted to a hospital for oral surgical procedures? The oral surgeon per-

forms operations to correct such conditions as cellulitis of the face, tumors and cysts of the jaw and mouth, fractured mandible, maxillae and facial bones, unerupted, malposed, impacted wisdom teeth. He removes teeth, torus palatinus (a protuberance on the surface of the hard palate), embedded roots, calculi (solidified deposits) from the sublingual and submaxillary glands and ducts. All of these conditions could, under normal circumstances, be operated upon under a local anesthetic in the dental chair of a private office or in the outpatient department of the hospital. But there are various types of patients, and there are many organic diseases which a patient who presents himself for oral surgery may possess. What might ordinarily prove a simple, uncomplicated oral surgical procedure for a healthy person, might become a complicated one for a patient who has rheumatic or any other type of heart disease, uncontrolled diabetes, blood dyscrasia, a liver disorder, active tuberculosis, a kidney disorder or pregnancy. This is not to state that patients with systemic disorders are not operable. However, they do require more careful attention from the oral surgeon, consultation between the oral surgeon and the physician, and more personal care before and after surgery.

Special patients . . requiring special attention are: the nervous patient, the child patient, and the elderly patient.

Part of the oral surgeon's patient examination will be the careful outlining of a case history. This helps him evaluate what the patient may need before or after surgery. If hospitalization is indicated the patient can be admitted to the hospital the day before the operation. If he is a private patient, his personal physician will examine him. If he is a staff case, the chief resident will examine him. Hospitalizing this patient affords the surgeon a better opportunity to study the case. Most oral surgical procedures consist of bone surgery which causes more trauma than the usual soft tissue surgery. If the patient is hospitalized he can be given more specialized treatment including a complete physical examination, urinalysis, complete blood chemistry, a test of clotting time of the blood, taking of blood pressure. These tests constitute a valuable adjunct to the case history. Many times such an examination reveals systemic disorders of which the patient was unaware such as hypertension, blood dyscrasia, diabetes or other disorders.

Other types of oral surgery . . are indicated when the patient, even though perfectly healthy, should be admitted to the hospital. One example is the complete removal of all remaining upper and lower teeth, followed by an alveolectomy and a gingivectomy. Such a patient is more comfortable if he is hospitalized the night before. A sedative is administered, usually insuring a good night's rest. In the morning another sedative is given. When the patient is taken to the operating room he is perfectly relaxed. He knows that facilities are at hand to care for any postoperative complications. Furthermore, he is unworried. His fear is allayed. He is by far a better anesthetic and operative subject.

The average patient may be surprised to read this. Often a patient expects to have an unerupted, malposed, impacted third molar tooth removed in the dentist's office while he is on his lunch hour, after which he confidently expects to return to his office. Or he may expect to have a calculus removed from the sublingual or submaxillary gland, late in the day after his work is finished, with no thought of any complication. This same patient, however, if he were advised by his physician to have a mole removed from the side of the face, would perhaps nonchalantly say, "Well, I have plenty of leave and hospitalization, so I can make the necessary arrangements any time you want me to, doctor." The oral surgeon must teach his patient the importance of hospitalization in certain cases.

Now that most individuals have hospitalization insurance, and most hospitals have an oral surgical staff, and a close cooperation between the various medical specialties and the specialty of oral surgery exists, the oral surgical patient has the advantage of more specialized care than was ever possible before.

In the writer's opinion, there is still too much major oral surgery being performed in the oral surgeon's office today. It is not that excellent oral surgery cannot be performed in his modern-day office, but the nature of the surgery may require that the patient be prepared the day before, both mentally and physically, and that he have care after the operation which cannot be had at home. ■

N. Y. hospitals plan executive post

■ FOLLOWING APPROVAL by its executive committee of a special committee report on reorganization, the board of trustees of the Hospital Association of New York State recently adopted the recommended plan for the appointment of a full-time executive director, together with other measures designed to give the organization an increased degree of headquarters activity. The new position will be filled during the next few months, probably before the meeting May 21-23 of the Middle Atlantic Assembly.

It was at once offered to Carl P. Wright, veteran secretary of the association, who has filled that position since 1933, but he refused it with thanks, on the ground not only that he could not give up his connection with the Syracuse General Hospital, but that the State position calls for a younger man.

It is proposed that Mr. Wright act as secretary and treasurer, retaining his hospital position, and giving the new executive director the benefit of his long experience. The association's reserves of nearly $40,000 will enable it to handle an increased budget without any immediate rise in dues.

New radioisotope research courses

■ THREE ADDITIONAL courses in the techniques of using radioisotopes in research will be offered by the Special Training Division of the Oak Ridge Institute of Nuclear Studies this summer. Dates for the courses:

June 9 to July 4
July 7 to August 1
August 11 to September 5 ■

housekeeping·laundry·maintenance

A hospital's chief engineer tells about changing from coal to oil

by **Arthur H. Parker** • Chief Engineer • Monadnock Community Hospital • Peterborough, N.H.

■ I HAVE BEEN OPERATING two of the most modern packaged unit boilers on the market for so long a period now that I feel qualified to write a, shall we say, expurgated account of my trials, tribulations, and assorted exasperations and aggravations.

I intend to be perfectly fair and shall dwell with equal emphasis on the satisfactions and economies of automatic oil burning operation. If the former outweigh the latter, that is, if there seem to be more aggravations than satisfactions, it *could* be that only Parker has had so many, many night hours of struggle . . hours such as he never had with the simplicities of the hrt's (horizontal return tubulars) of other days of nostalgic memory. Let us sincerely hope that few other engineers received their baptism of oil, as *I* did, the hard way.

In the beginning . . To begin with, I didn't know one single thing about burning oil. I had shovelled, thrown and pushed thousands of cords of wood and wood waste under many different boilers and had scooped hundreds of tons of coal, through a period extending from Feb. 3, 1909 until Nov. 30, 1949. As I look back on them *now* . . 40 happy, carefree years.

Some time after we knew that there was to be a new boiler to go with our new construction and additions I saw it on a flat car at the depot. "Jimmy Crickets," I muttered to myself, "will *I* ever be smart enough to find out what all those many gimmicks do and moreover will I be bright enough to fix 'em when they go haywire."

Eventually the new boiler room was built with one boiler piped up for water, steam and oil.

It was a bitter, cold, late November night. It had rained hard all the previous 24 hours. I was wet to the skin. The old 30 hp hoisting boiler, which had furnished high pressure steam for laundry, sterilizers, etc., set up out in the backyard while the old boiler was being taken out, had finally laid down on the job. Steam, which should have been at 80-100 psi, had dropped to 26 and was showing every indication of doing no better. The new oil burner was ready to go but the expert . . where, oh where was he? I climbed up on the sketchy roof protecting the fireman of the hoisting boiler and shut off the main valve. I called up the superintendent and told him, "in a few, well chosen words," that, so far as *I* was concerned, Monadnock Community Hospital was all done until somebody showed up to get our new oil burner on the line.

Expert appears . . At 11 p.m. the expert appeared. I imagine the "Boss" had made it hot for somebody. He knows how.

There was a whole lot of difficulty in getting the oil pump to draw oil from the 15,000 gal. underground tank and it took a long time to get steam up in the cold boiler. No doubt the house got pretty chilly but there were plenty of blankets and probably no one suffered.

So now, here I am . . Nov. 30, 1949 . . in charge of a brand new 125 hp, oil burning, packaged unit boiler, as modern and up to date as tomorrow's newspaper . . and about which I possess only a jumbled assortment of untried facts, culled from a voluminous manual. I had studied this manual at each and every opportunity. I took it with me while a guest at a family Thanksgiving get-together and dinner.

I didn't actually astonish the other guests by bringing it to the table with me, there to grasp manual with one hand and wing, drumstick or neck with the other. But to all intents and purposes I did just that. When tempted to take a hand in the hectic bid whist and pitch games, which always enliven our family parties, I hearkened not to the voice of the tempters but kept right on studying. And it is a mighty good thing I did.

The phone rings . . Nothing could be sweeter than the way the new boiler carried on all through the night and the next day . . up until about 6 p.m. Or maybe a little later. I was at home a mile and a half from the hospital, contentedly reading the last S.E.P., when the phone rang.

MECHANIZE 4 Scrubbing Operations into 1

with a COMBINATION SCRUBBER-VAC!

Here's a timely answer to the need for conserving manpower and reducing labor costs—*a single cleaning unit that completely mechanizes scrubbing.* A *Combination Scrubber-Vac* applies the cleanser, scrubs, rinses if required, and picks up (damp-dries the floor)—*all in one operation!* Maintenance men like the convenience of working with this single unit... the thoroughness with which it cleans... and the features that make the machine simple to operate. It's *self-propelled*, and has a *positive* clutch. There are no switches to set for *fast* or *slow*—slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs efficiently and quietly.

Model 213P Scrubber-Vac at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread, and cleans up to 8,750 sq. ft. per hour! (Powder dispenser is optional.) *Finnell* makes *Scrubber-Vac Machines* in a full range of sizes—for small, vast, and intermediate operations—and in *self-powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac*, and that *there's a Finnell man nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 2703 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

Conserve Manpower with Completely Mechanized Scrubbing

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

Oh, my stars and garters . . Oh, hell's bells and panther tracks! That wonderful new boiler had conked out. There was no steam. There was no heat. There *was* gooey black No. 5 oil over quite a large area of the boiler room floor. The oil feed pipe to the burner had broken off between oil pump and burner.

The men on duty hesitated to leave the boiler so they sent the *laundress* down after me. So far as we knew, the expert was still in town, intending to appear at the hospital occasionally to check up on operations and to give me instruction and good advice.

Our immediate job was to locate this most important individual . . our only salvation. Never sank my heart so low as when it become apparent that he wasn't in town. We went to the movies, to the hotel, to

Are aluminum windows useful to hospitals?

■ THE ADVANTAGES of aluminum windows in hospitals have been listed by representatives of the Aluminum Window Manufacturers Association as follows:

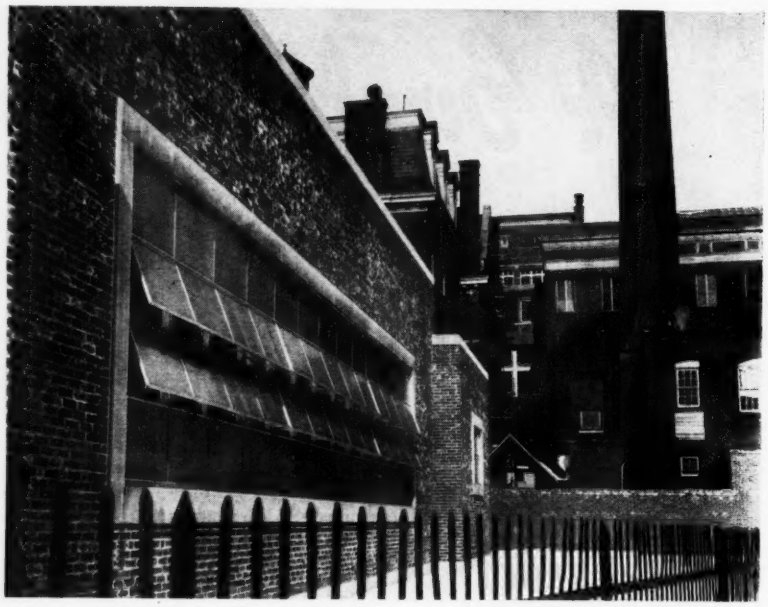
1. Contribute to cleanliness.
2. Admit maximum health-giving sunshine.
3. Eliminate restrictive feelings.
4. Provide maximum fresh air.
5. Contribute to feeling of well-being through beauty of aluminum sash, blending with practically all types of architecture and fitting into almost all interior decorating schemes.
6. Help to eliminate drafts.
7. Aid maintenance of even room temperatures.
8. Add to safety of patients.
9. Contribute to convenience of patients.
10. Symbolize health.

The association also makes the point that aluminum sash will not rot, warp or swell. There are no drip stains from it. It does not need paint. It points to one of the earliest installations at Marcy State Hospital, Utica, N.Y. as an example of lasting value and maintenance savings.

The most recent aluminum use in hospitals is that of Bradford Hospital, Bradford, Pa., where not only the window sash but the exterior of the building are aluminum.

Aluminum windows leave the factory completely fitted, weather stripped and with balancing devices and hardware furnished. The association also has standardized architectural specifications for aluminum windows. It also has established standards of manufacture, the attainment of which is indicated by a seal.

The new Bellevue Medical Center, New York City, shown on this month's cover, will have aluminum windows. ■



Humid conditions such as in this boiler plant at Presbyterian Hospital, Philadelphia, Pa., were met by the architects, Thompson & Mecaskey, by specifying aluminum windows

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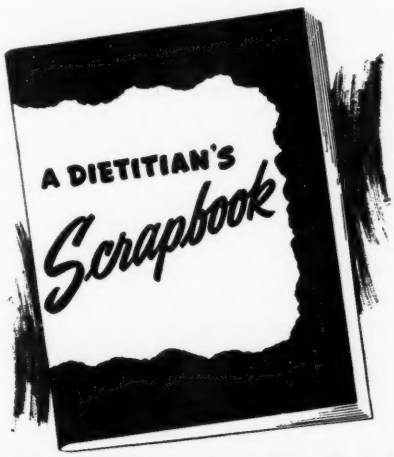

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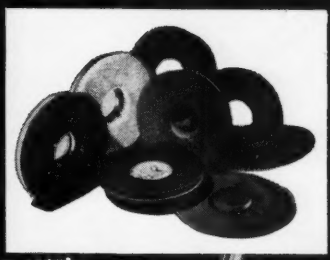

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a (not to put too fine a point upon it) beer joint, to our local lunch cart (called, unfairly I am sure, the "Greasy Spoon") . . all to no avail. We enlisted the services of the local constabulary . . still to no avail.

If you can remember a time when you were so low down on your luck that there was no place lower to go you can think of me at that moment when it became apparent that *I* and I alone must cope with the emergency, as being several sub cellars lower than *you* ever got.

Mechanically, with the help of the blunt end of a small die stock and a hack saw, I was able to cut and flare the oil tubing and to replace it so that oil could be fed again to the burner nozzles. *Now*, I had to start the boiler for the very first time. I don't need to tell how scared I was. I was actually panicy.

By this time I was surrounded by concerned officials, board members, staff members, interested bystanders, several of my engineering group, two or three Joneses (none of them the Jones of whom we stood in desperate need). It seemed that *our* Jones, the e x p e r t, had been paged at the movies. Just why Tom, Dick and Harry Jones felt they could be of any use in an unknown emergency wasn't, at the moment, clear. At least they meant well.

Time went by and I simply could not get that cussed boiler going. With the small amount of information I had been able to absorb I was *sure* that, if the burner didn't fire immediately, we all stood a good chance of getting blown to Kingdom Come. And so I kept on and on . . stopping and starting that miserable recalcitrant oil burner. Nothing happened.

An idea works . . Finally I had an idea. I figured the burner was getting so much so-called "secondary air" that the atomized oil was blowing away from the nozzles before it could get a chance to ignite. "Gentlemen," I announced, "I am going to take a chance. *You'd* better move back. If *I* get blown up it's my hard luck. I don't need all this company to see me through the Pearly Gates."

I snapped the switch, I draped my cap over a part of the blower intake, there was an instant, oh so welcome, flash of flame at the nozzles and the ordeal was over. The collective sigh of relief that went up from the throats of that anxious group could have been heard, it seems, as far west as Chicago.

I had worked with one of my engineering group . . the third trick man . . for years. He had never heretofore given me a kind word. As he turned to leave the boiler room he said, with every evidence of sincerity, "Parker, you did a mighty good job and I'm proud of you."

After it was all over the expert showed up . . surprised no end. He had been out of town to get a haircut.

This oil pipe failure was the first of four failures with tubing due to vibration. It finally became necessary to do something, ourselves, to prevent future breaks and shutdowns. One of the messiest jobs in this world is to clean up a boiler front and boiler room floor after several gallons of black, sticky No. 5 oil have sprayed over everything in the immediate vicinity.

We corrected the difficulty by forming a so-called "pig tail" in new tubing, replacing all tubing which could be broken or cracked by vibration. A "pigtail" is about what it sounds like . . a circle in the pipe or tubing. This circle absorbs vibration . . not, perhaps completely, but very effectively. We have had no breaks in the tubing so provided.

These modern boilers are 100% automatic. If each and every one of the many gadgets and gimmicks functions as it should, about the only use a chief engineer has for his head is as a place to grow hair and to park his hat. When you snap the switch to start the burner everything from then on is taken over by burners, blowers, air-oil pumps, electric contacts whose purposes are legion, coils, m e r c u r y tubes, high and low pressure cut-ins and cut-outs, low water cut-outs, pump controls, etc.

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3-52

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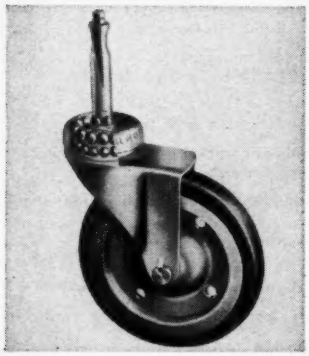

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To the poor chief it seems that *plenty* could be found anywhere but in his boiler room where something has gone haywire but he doesn't know what. He pushes in the low water cut-out resets. Nothing happens. He takes off the covers of four mercury tube controls. *They* are all right . . all contacts being made as they should be. He jiggles a red emergency button. Nothing happens. He makes several other futile checks. (cont. p. 152.)

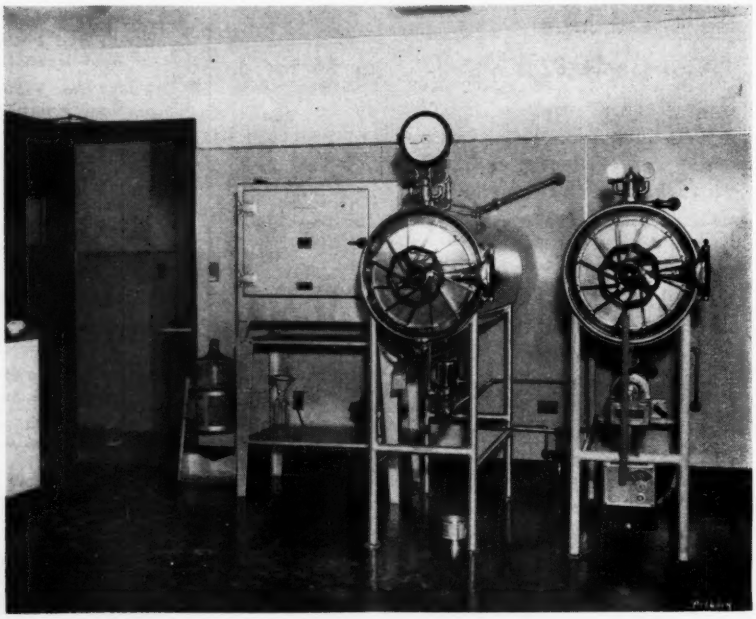
New York hospital tries pre-finished paneling

■ PRE-FINISHED PANELING . . 18,000 feet of it . . has been installed in Eastern Long Island Hospital in New York in an effort to achieve a colorful interior which is easy to maintain and long lasting.

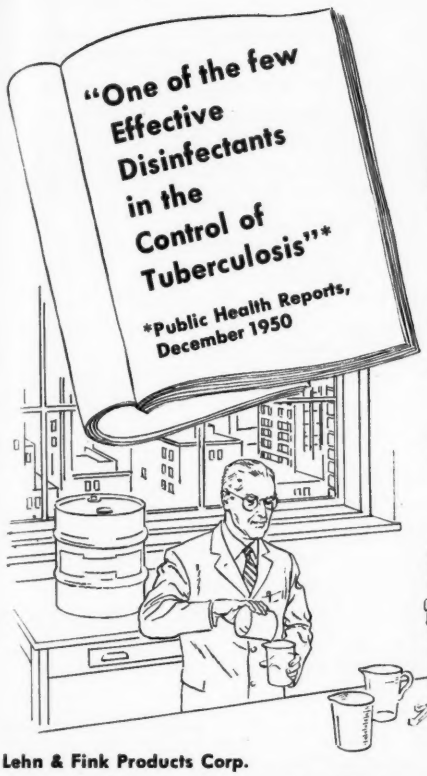
For example, one of the operating rooms features a vertical, full-wall treatment of paneling in light green, while the scrub-up room has as its decorative keynote a wainscot treatment of suntan panels.

Other areas in this hospital remodeled with prefinished wallpanels include a sterilizer room, with eggshell paneling; central sterilizing room, also with walls surfaced in eggshell; and the lobby, where a mahogany-patterned panel wainscot is installed. For contrast, the information booth features a wainscot of paneling in the Prima Vera (natural) pattern.

Extensive use of prefinished wallpanels in this hospital underscores their decorative flexibility and adaptability to any architectural theme or design scheme. They are available in more than 60 different colors . . ranging from the pastels to the currently popular decorator-styled deeptones . . as well as in attractive tile horizontaline, parallel-scoreline designs. Even patterns simulating marble, granite, Spanish or Moroccan leather can be had. ■



Paneling . . shown in sterilizer room, Eastern Long Island Hospital



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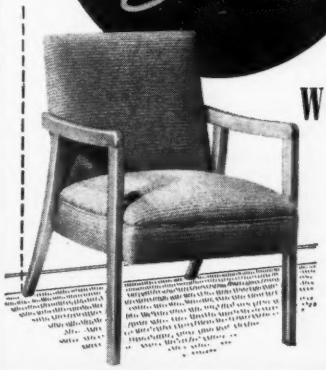

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Finally he takes the dome off the low water cut-out and pump control. Success at last! For some unknown reason the reset has failed to completely reestablish contact in the mercury tube. There is a small gap between the two ends of the pool of mercury. Unless he had taken off the dome the boiler never could have started without the services of an expert . . many miles and several hours away from an institution completely at a standstill.

The record . . An incomplete record of our various mishaps would drag on to great and tedious lengths. I have no intention of boring the reader with all our many troubles and problems. I *would like*, however, to include a short list of the unexpected failures which made my life nothing short of acute misery in 1950 while I was proving to myself and others that, up to the present moment, Parker was equal to the worst the boilers could do to him.

March 7 . . "Pump and motor separated at coupling. Boiler shut down on both regular and auxiliary low water cut-outs." This, of course, was no boiler failure.

March 10 . . "Boiler shut down. Found trouble in low water cut-out. Plenty of water. Probably someone working in the boiler room accidentally hit the water column and jarred the mercury tube enough to break contact."

April 10-11 . . "Boiler stopped several times. Low water cut-out shut boiler down with water in normal position. Adjusted mercury control ½ turn of adjusting screw."

April 12 . . "Coil on oil valve burned out. Could smell burning insulation before locating trouble. Burst into flame just as I shut the boiler down. New coil required."

Oct. 5 . . "Belt broke on No. 1." Don't like the corrugated belts supplied by the boiler maker.

Oct. 6-16 . . "Occasional starting failures with No. 2 and occasional conkouts."

Oct. 25 . . "Called at 2 a.m. for broken oil line on No. 2. No. 1 down at same time for leaking nipple."

Dec. 25 . . "No. 1 boiler conked out, sooted up, or so I assume."

Dec. 26 . . "No. 2 down. Pump didn't stop. Boiler full of water."

This list, as already remarked, is by no means complete. I have had to use a certain amount of caution in order to prevent recognition of the make of boiler which has bedevilled us so frequently. Being more explicit could hardly be considered "cricket."

From the standpoint of the boiler company, any individual in charge of their product should be competent to deal with each and every emergency. From the standpoint of the hospital, as I have frequently outlined to our manager, such an individual costs real money. Furthermore, for ideal conditions, every member of the engineering staff should be equally competent. This would put more of a strain on the exchequer than it could reasonably be expected to stand.

The management requires and expects the chief to tell his men all he knows and has found out the hard way about the boilers. The chief does try . . but he has verified a fact he was already pretty sure of. 'A little learning can be mighty dangerous.' He finds that going on half a century of engineering experience becomes inadequate when faced with problems which he has never faced before. He has to use every iota of his wit, intelligence and ingenuity together with all his Yankee determination to never give up. How then can a lesser member of the staff, with a comparatively short period of service in his first boiler room, be expected to master problems which frequently have the chief out on a limb? *I'll* say it is too much to expect.

The other side . . The other side of the picture presents several telling points. Our boiler room actually shines. Perhaps it is one of the brightest and cleanest in the whole state. It *could* be cleaner . . occasionally a day passes when no one has time to get around with broom and feather duster.

Indubitably we are saving money on our fuel accounts . . a whole lot of it. Right now we are providing *all* the steam used in the whole institution with slightly under 12 gallons of No. 5 oil per hour. Next summer, when the heating season is over, four gallons an hour will take

continued on page 155

Chief engineer

continued from page 152

care of laundry, hot water supply, sterilizers, etc. Our over-all fuel expense for last year was one cent a minute or $14.40 per day.

The real value of these figures would lie in our being able to compare them with other figures such as the cost when we were burning soft coal. This we are unable to do. At no time did we carry the load we are carrying now when burning coal.

Before our new addition was erected . . two stories and basement, 60 x 90 feet . . we burned, in mid-winter, a 50 ton carload of coal in five weeks. This coal at that time cost us $16.50 per ton in our bunker. Our daily fuel expense was thus $23.57. It will be plain that our saving is indeed an important one.

The fuel problem has been simplified in still another important way. All we have to do now is to call Greenville 86 and tell them we can use another truckload . . 4,250 gallons . . of No. 5. It will be here the next day or the day after. Before we stopped burning coal the supply became a real problem and headache. Time was when we could plan on two-week deliveries . . but not in the later coal burning years. If our long awaited car showed up in a month we considered ourselves lucky. You get mighty nervous when there is only a few days' supply of coal in the bunker . . zero weather, maybe, and no coal in sight.

No smoke, no ashes. Most of the time I am sure you could hold a clean handkerchief over the stack with no diminution in its state of cleanliness. And this clean stack poses another problem for the chief. He has no way now to predict the weather. He used to be almost sure fire in the old days when heavy clouds of smoke, torn from the stack by stiff northwest winds or wafted gently by soft southern zephyrs, announced to this weatherwise prophet, meteorological conditions for days to come. *Now* when they ask the chief, "What's it going to do tomorrow, Parker?" the best I can tell 'em is that "Wetherebee, the WBZ weatherman, says it's going to snow . . mebbe." ■

Architect-physician roles

continued from page 49

tion and treatment facilities, including separate areas for insulin and electric shock, are amply provided; the nursing units are small and most of the bedrooms are single rooms, the largest being for four beds; two living rooms are provided on each nursing unit. There are areas for visitors, dining, and occupational therapy. An exercise gym and a hydro-therapy pool are included.

Analysis . . These examples are not cited to indicate that we should depart from precedent, but rather to show that experience and procedure must be analyzed in order to determine the functions and resulting arrangement when planning new projects. On the other hand, we should not be afraid to experiment with new arrangements when they describe the function properly, even though new building forms result.

It is the architect who accepts final responsibility for the building. He designs many buildings, for which the staffs come and go, and he will be interested in producing a design which will provide for the efficient operation of all its functions rather than in maintaining a precedent which may have little or no relation to the procedures which it is to house.

Design necessarily influences procedure, as well as vice versa.

Doctor Karl Menninger has very correctly spelled it out for us when he said, "It is a fact too seldom reflected upon that the architects of today determine the procedures and practices of tomorrow."

Summary . . Without general and detailed information, the architect and physician do not have a common ground or language to understand what is required of each. Each has the experience to provide planning data which would be useful to the architect, had he but the means to avail himself of it. It is desirable that the total experience of all methods, both new and old, continue to be evaluated, and the evaluations made available for use in programming, planning and detailing a project. ■

Early tests

continued from page 114

volved at Hoffmann-LaRoche, had mentioned Rimafon at the International Congress of Chemists in New York last September, "although at that time he did not reveal the results already achieved with the drugs in tuberculous infections." After relating in detail the story of the development of the two drugs and the experiments conducted to determine their effect on both animals and human beings, including the Sea View group beginning in June, the release concluded:

"Up to now, Rimafon and Marsilid have been prepared only in very limited quantities for clinical investigation. If these drugs should prove to be suitable for general use, commercial production will have to be started and until that time the cost of these compounds will not be definitely known."

New York officials in welfare row

■ NEW YORK STATE Welfare Commissioner Robert T. Lansdale on Jan. 27 accused the city of New York of inefficient management of welfare matters, declaring that overpayments ranging up to totals of $5,000 per case were revealed by his investigations, and indicating that $200,000 in welfare aid would be withheld for this reason. His charges were based upon a review of 1,000 cases last year and the discovery of various irregularities which were not adequately explained.

Prompt denial of these criticisms was voiced by city authorities, including Commissioner of Welfare Henry L. McCarthy and others, Mr. McCarthy pointing out that Federal funds for aid in welfare are paid to the State and suggesting that the State has not fairly distributed these funds, particularly a recent payment said to amount to $25,000,000.

The matter is of direct interest in view of the several proposals of the city for additional taxes, which are now before the State legislature, and of the fact that the State pays 50 per cent of the total metropolitan welfare load, with the Federal government contributing 30 per cent. The total welfare budget for the current fiscal year is $179,765,800. ■

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Should storms, floods, fires or breakdowns strike, an electronic brain—the Onan TRANSWITCH, starts the electric plant automatically and within seconds delivers vital electric power to operating rooms, obstetrical rooms, stairways, alarm system, telephones, blood bank refrigerator and every critical point. Power outages are no longer dreaded.

In hundreds of institutions like Beth Israel Hospital, in which power interruption can endanger lives or cause serious disruption of important service, Onan *Power-Guard* Electric Plants insure the power supply. If you are contemplating emergency electric power for new buildings or replacing an inadequate system with an engine-driven generating plant, Onan engineers will, without charge, make a recommendation as to which Onan model will best suit your needs.

D. W. ONAN & SONS INC. 7359 UNIVERSITY AVENUE, MINNEAPOLIS, MINNESOTA

Write for complete information and a list of hospitals that now depend on Onan Power-Guard Electric Plants to insure lives and services against power failure.

Onan PRODUCTS

ONAN *Power-Guard* Electric Plants